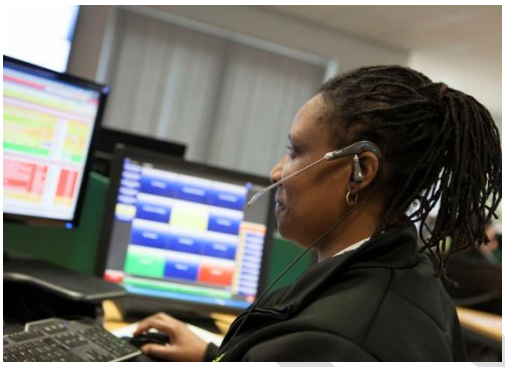
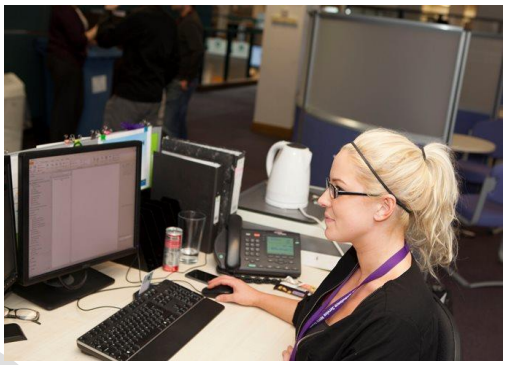
NHS
Yorkshire
Ambulance Service
NHS Trust

Yorkshire Ambulance Service Annual Report and Financial Accounts 2017-18

Final Version

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Introducing Yorkshire Ambulance Service

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

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

We employ 5,737* staff, who together with over 1,150 volunteers, enable us to provide a vital 24-hour, seven-days-a-week, emergency and healthcare service.

* is a headcount figure which includes part-time staff and equates to 4,422 whole-time equivalents.

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 NHS 111 urgent medical help and advice line
- the delivery of GP out-of-hours (OOH) services in West Yorkshire in partnership with Local Care Direct
- take eligible patients to and from their hospital appointments and treatments with our non-emergency Patient Transport Service (PTS).

In addition we:

- have a Resilience and Special Services Team (incorporating our Hazardous Area Response Team) which plans and leads our response to major and significant incidents such as those involving public transport, flooding, pandemic flu or chemical, biological, radiological or nuclear (CBRN) materials.
- provide clinicians to work on the two helicopters operated by the Yorkshire Air Ambulance charity
- 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. We also run co-responder schemes with Fire and Rescue Services in parts of Yorkshire and the Humber as well as a number of volunteer car drivers who support the delivery of our PTS.

We are led by a Board of Directors which meets in public quarterly and comprises the Trust chairman, five non-executive directors, five executive directors, including the chief executive, and four directors (non-voting).

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

Our priorities for 2018-19 include:

- Delivering safe, compassionate care which promotes the best health outcomes for patients in urgent and emergency care through high quality and effective clinical processes and pathways.
- Continually supporting the wellbeing of our staff and volunteers through education and promotion of a culture founded on our values.
- Developing an integrated workforce which values the diversity of multi-professional groups.
- Maintaining financial stability and achieving our agreed level of financial performance.
- Delivering the performance standards required within the national Ambulance Response Programme (ARP).
- Continuing to develop non-emergency patient transport services across the region, aligned to the wider system and supporting patient flow.
- Developing our service offering around the integrated urgent care national specification and retaining the NHS 111 integrated urgent care service.
- Maintaining and improving our ‘Good’ rating with the Care Quality Commission ratings.
- Enhancing our digital capability to ensure we identify and utilise key technology to support effective and integrated services for our patients.
- Ensuring we have robust plans in place to attract, recruit, develop and retain our valued workforce.
- Embedding the Trust’s new Behavioural Framework: *Living our Values.*
- Working as part of our local Sustainability and Transformation Partnerships (STPs) and shadow Integrated Care System (ICS) to improve patient care through a joined-up and efficient approach.

- Working with ambulance and other emergency service colleagues, including our neighbouring ambulance trusts North East Ambulance Service and North West Ambulance Service, which along with YAS form the Northern Ambulance Alliance, we will continue to identify and deliver efficiencies in the way we work. (East Midlands Ambulance Service has also joined the Alliance as an associate member.)
- Increasing our patient engagement and using their experiences to help shape developments at the Trust.
- Developing a robust and effective approach to corporate social responsibility which sets out clear engagement with our local communities, provides community education and support and which contributes to increased public health awareness and better health outcomes.
- Focusing on the development of all our leaders, leading cultural change and promoting a 'One Team' culture. Our *Leadership in Action* development programme will focus on our senior and middle leaders, supporting delivery of the requirements within the Well-Led Framework.

Our Purpose, Vision and Values

Our Purpose
To save lives and ensure everyone in our communities receives the right care, whenever and wherever they need it.

Our Vision
To be trusted as the best urgent and emergency care provider, with the best people and partnerships, delivering the best outcomes for patients.

One Team

- We share a common goal: to be outstanding at what we do.
- We are collaborative and inclusive.
- We celebrate success together and support each other, especially through difficult times.

Innovation

- We pioneer new ways of working.
- We are at the forefront in developing professional practices.
- We have a positive attitude and embrace challenges and opportunities.

Resilience

- We always support each other's mental and physical wellbeing.
- We have the flexibility to adapt and evolve to keep moving forward for patients.
- We remain focused and professional in the most difficult of circumstances.

Empowerment

- We take responsibility for doing the right thing, at the right time for patients and colleagues.
- We are willing to go the extra mile.
- We continuously build our capabilities through training and development.

Integrity

- We are open and honest.
- We adhere to professional standards and are accountable to our communities and each other.
- We listen, learn and act on feedback.
- We respect each other's point of view.

Compassion

- We deliver care with empathy, respect and dignity.
- We are passionate about the care of patients and their carers.
- We treat everyone fairly, recognising the benefits of living in a diverse society.
- We listen to and support each other.

Chief Executive's Foreword

Welcome to our 2017-18 Annual Report which will provide you with an overview of the Trust's operational activity and key developments over the last year.

As with all areas of the NHS we experienced significant pressures on our services during 2017-18. Despite this I'm pleased to report that the Trust continues to make good progress against its strategic and operational priorities.

We remain committed to continually improving the quality of care we provide for our patients and the communities we serve. Ensuring patients receive the right care when and wherever they need it is at the heart of this commitment. This is being achieved by increasing the frontline clinical skills within our NHS 111 and 999 call centres and on our ambulances, as well as working with our system partners to convey patients to appropriate local facilities or regional centres of expertise.

Following our involvement in the national pilot stages of the Ambulance Response Programme (ARP), we went live with reporting against new incident categories at the beginning of September 2017. We, along with South Western Ambulance Service and West Midlands Ambulance Service, have played a key role in the development of the ARP and it's fantastic to see it coming to fruition and being rolled out across the country by NHS England. The programme is pivotal to delivering quality improvements and transforming how ambulance services run their emergency operations in the future. It also influences how we work collaboratively with wider healthcare services to provide more integrated care for patients.

Aligned to this work we have made good progress in improving call-answer times in our emergency operations centre (EOC), increasing rates of 'Hear and Treat' telephone advice and improving vehicle dispatch.

We have continued to recruit additional staff to frontline operations in 2017-18, and in 2018-19 we are planning to increase the number of double crewed ambulances on the road and clinical advisers within our EOC to address the challenge of increased demand. We also continue to work closely with hospitals across the region, particularly those which have struggled to cope with capacity pressures.

Our 999 and NHS 111 urgent care service responded to more calls than ever before. Our NHS111 service in particular answered over 1.6 million calls during 2017-18, an increase of nearly 5% on 2016-17. The regional contract to provide this service is being re-tendered during 2018-19 and we are committed to trying to retain this service, ensuring continued benefits of aligning 999 and NHS 111 services

In January 2018 we were proud to be awarded the contract for non-emergency ambulance transport for the Vale of York and Scarborough. The retention of this contract follows similar contract wins in South Yorkshire and the East Riding and underlines the significant improvements to service delivery and efficiency through the Trust's Patient Transport Service (PTS) Transformation Programme.

The Trust has played an active part in planning the future of emergency and urgent care services in Integrated Care System (ICS) and Service Transformation Partnership (STP) footprints in South Yorkshire and Bassetlaw, West Yorkshire and Harrogate, Humber Coast and Vale.

Collaboration with our neighbouring ambulance services as part of the Northern Ambulance Alliance (NAA) has developed further in 2017-18 and our closer working relationship is aligned to the three key aims:

- Improving the quality and service delivery for patients.
- Maximising standardisation opportunities at scale and reduce duplication.
- Reducing the overall costs of the collective budgets of the three services.

We have seen a number of successful collaborative initiatives in fleet, procurement and clinical support. Efforts to realise opportunities in collective back-office functions saw YAS's Payroll Team take on responsibility for the administration of North East Ambulance Service's payroll in February 2018. In addition, East Midlands Ambulance Trust has now joined the NAA as an associate member which allows them full participation in collaborative work-streams and offers the Alliance potential access to further economies of scale.

Good progress is being made developing the Trust's future strategy which will position us to meet the challenges and opportunities of urgent and emergency care integration and supporting local systems of care to deliver more responsive services within communities.

Continually improving the quality of care we provide to patients and making YAS a better place to work are at the core of our strategic planning and day-to-day actions. The Trust's new values and our refreshed Diversity and Inclusion Strategy are central to this. In January 2018, following extensive staff and stakeholder engagement we officially launched our Behavioural Framework, *'Living our Values'.* It represents our personal commitment to ensure our vision, purpose and values underpin everything we do, what we stand for and what we aim to achieve as a team.

During the year we have strengthened our senior leadership team which includes the appointment of Christine Brereton to the post of Director of Workforce and Organisational Development. Christine has a wealth of NHS and public sector experience and her teams have taken the lead on developing our refreshed vision, values and behavioural framework.

Looking forward 2018/19 will be another significant year:

- We will be embedding the ARP in our EOC and A&E Operations, bringing over 60 additional new ambulances into service and increasing clinical staff within our EOC and frontline operations.
- Technology has a significant role in supporting improved clinical decision-making and integrating health and social care. During 2017-18 the Trust has developed its own electronic patient record (ePR), providing information for internal and external clinicians in a paperless format. It has been piloted initially in South Yorkshire and will be rolled out more widely across the Trust during 2018-19.
- We will be supporting the delivery of care closer to home, working with local care systems to make best use of use of new urgent treatment centres and the development and embedding of advanced paramedic roles within communities.
- We have successfully operated the NHS 111 contract across Yorkshire and the Humber for over five years and in the coming year a dedicated team will be working hard to ensure we retain this contract and continue to realise the benefits for patients of the close alignment of NHS 111 and our 999 service.
- We will begin construction of our first ambulance 'hub' at Doncaster which will see the existing ambulance station in Clay Lane West extensively remodelled with the very latest clinical and operational practices. We will also be rolling out our ambulance vehicle preparation (AVP) services in Leeds and Huddersfield, giving clinical staff more time to focus on patient care.

I would like to take this opportunity to formally thank Pat Drake who left the Trust in March 2018 and Barrie Senior in November 2017 as their terms of office came to an end. Pat gave eight years' service to the Trust as a Non-Executive Director, Chair of the Quality Committee and Deputy Chair. Barrie served for five years as a Non-Executive Director and Chair of the Audit Committee.

I would also like to thank all of our staff and volunteers for their continued dedication and compassion in providing care for our patients and being there for them in their hour of need. A snapshot of the amazing work our staff do has been captured this year as part of the *Helicopter ER* and *999 Rescue Squad* series which have been well received by viewers across the country. It makes me immensely proud to see what a difference staff make to patients every day and it is a privilege to lead the organisation.

Rod Barnes
Chief Executive

Chairman's Report

Following my introduction to the ambulance service back in 2016, I've nearly completed my initial two-year term. I continue to relish my role as Chairman and am thrilled to have been reappointed for a further two years from 1 July 2018 until 30 June 2020.

The organisation is undergoing a massive period of change with our new values and behavioural framework at the heart of this transformation. I'm hugely proud of the work that has gone into developing these and, in particular, the valued input from staff. I'm looking forward to seeing the effect of the values and behavioural framework on the culture of the Trust as they become embedded and am convinced that their long-term effect will be for the better. YAS is committed to being an excellent employer and we want everyone to have a good experience of working at the Trust. The leadership conference we held in September 2017 was one of my highlights of the year and I have a lasting memory of the 200 attendees welcoming and accepting the new values as a fresh way forward.

I'm also excited by the Quality Improvement Programme we are running and this includes the introduction of our Quality Improvement Fellows who will focus on taking forward improvement ideas from across the Trust. It's a great example of where our staff can have greater involvement in the future direction of the Trust and 5,000+ YAS employees can help to ensure we take the right path. This puts staff at the heart of delivering excellent care for patients.

I would like to pay tribute to our Chief Executive, Executive Director of Finance and the Executive Team for their efforts in ensuring that the Trust is in a good financial position. I truly believe this is based on good management and not good luck!

I acknowledge that future years will be difficult, but YAS is in a good position to meet these challenges.

Our community engagement programme has continued throughout the year and helped deliver key public health messages and raise awareness of the fantastic work our staff do. This ensures that our public stakeholders have the opportunity to be kept well informed and can provide us with feedback on their experiences too.

In 2018-19 we will be taking forward the full implementation of the Ambulance Response Programme (ARP). It's a significant change to the way in which we and other ambulance services are working and it should help to ensure patients get the right response appropriate to their needs first time.

Our other priorities are winning a second tenure to deliver the NHS 111 contract in Yorkshire and the Humber, securing the West Yorkshire Patient Transport Service (PTS) contract, delivering our financial control total and, of course, embedding our new values.

Thanks go to all of our wonderful staff who do a tremendously hard job every day with dedication, compassion and the utmost care for our patients.

Kathryn Lavery
Chairman

Performance Report

Operational Review - Caring for our Patients

A&E Operations

The Trust was one of the first English ambulance services to participate in the Ambulance Response Programme (ARP) pilot led by NHS England. We have continued to be involved through all phases of the pilot which has allowed extra time for emergency call handlers to make a more detailed analysis of some 999 calls and to decide upon the most appropriate response for patients' needs. During 2017-18 NHS England announced that it would be introducing the new ambulance response standards across the country.

We recognised that it was a great opportunity for YAS to be involved in the ARP from the start as it has allowed our staff to make a full contribution to the pilot and to help shape the recommendations for changes to ambulance response standards.

Ultimately, providing safe patient care and responding to patients more effectively has been at the heart of the changes we have trialled and is the result of rigorous testing of new ways of working.

Early identification of truly life-threatening conditions is vital and having appropriate ambulance resources available to dispatch to the scene will give patients the best chance of survival. We are now able to deploy our frontline clinicians more effectively, ensuring that patients get the most appropriate response for their needs. In addition, the ARP has given us a greater opportunity to work closely with our healthcare partners to develop care pathways to better meet patients' needs and this does not always involve conveyance by ambulance to hospital.

Critical Care

A Consultant Paramedic in Emergency and Critical Care has been appointed to provide senior clinical leadership and support. We have introduced pre-hospital blood transfusion for the Yorkshire Air Ambulance to assist with the management of severe haemorrhage in major trauma and we have further developed the Red Arrest Teams who provide leadership and advanced clinical skills at cardiac arrests, with the teams now being able to administer antibiotics for open fractures.

This year has also seen the development of a region-wide casualty dispersal matrix for major incidents, which means that we have a pre-agreed system with acute trusts for casualty movement in the early stages of a major incident.

Clinical Supervision

We have implemented and supported the preceptorship for newly qualified paramedics by providing clinical leadership, supervision and increasing the availability of advice through the Clinical Hub in our emergency operations centre (EOC).

We have also strengthened the role of the clinical supervisor in developing and supporting frontline clinicians to deliver high quality, patient-centred care.

A Consultant Paramedic in Urgent Care has been focused on embedding the College of Paramedics career framework, supporting specialist and advanced paramedics in urgent care, providing clinical leadership and supporting clinical governance and quality of care.

We have explored new ways of working with acute trusts and community care by supporting and piloting specialist and advanced paramedic roles in these healthcare settings.

In addition, we are continually reviewing, developing and expanding existing pathways for use by specialist paramedics enable us to deliver care for patients closer to home.

Ambulance Response Programme Performance Standards
The ARP was established by NHS England in 2015 to review the way ambulance services operate, increase operational efficiency and to ensure a greater clinical focus. It has helped to inform changes in national performance standards.

In collaboration with providers, commissioners and stakeholders, the ARP has been designed to change the way ambulance services respond to 999 calls, in terms of both the time to respond (performance) and the prioritisation (clinical coding) of patient conditions, which determines the associated response standards.

The former Red 1 and Red 2 national standards have been retired with a new call prioritisation system introduced which sets standards for all 999 calls to ambulance services.

The new categories are as follows:

Category 1 – Life Threatening
This is defined as a time critical life-threatening event requiring immediate intervention or resuscitation.

Category 2 – Emergency
This is defined as potentially serious conditions that may require rapid assessment and intervention.

Category 3 – Urgent
This is defined as an urgent problem that needs treatment to relieve suffering but is not immediately life-threatening.

Category 4 – Non-Urgent
This is defined as problems that are not urgent but require assessment.

In line with clinical guidance, each category has set criteria to establish the required resource, transport and response times to ensure that the right resource gets to the patient, first time, every time and within time. The current Ambulance Quality Indicators (AQIs) measuring performance are no longer considered appropriate measures for a modern and responsive ambulance service capable of delivering a variety of clinical interventions. A revised set of measures, indicators and standards has been developed and is widely supported by commissioners, ambulance providers, paramedics, unions and patient and public representatives.

The clinical conditions within the four categories may mean that a different response and prioritisation is applied to 999 calls in comparison to the previous Red 1/Red 2 standards.

Historical information on performance will remain available via the NHS England website, however, will no longer provide a like-for-like comparison to response times performance in previous years.

A&E Performance against National Targets

In 2017-18, our EOC staff received 922,328 emergency and routine calls, an average of over 2,500 calls a day. We responded to a total of 780,383 incidents through either a vehicle arriving on scene or by telephone advice. Clinicians based in our Clinical Hub which operates within the EOC triaged and helped just under 140,000 callers with their healthcare needs.

Performance against National Targets (1 September 2017 to 31 March 2018)

	Mean	Target	90th Centile	Target
Category 1	7 minutes and 46 seconds	7 minutes	13 minutes and 49 seconds	15 minutes
Category 2	24 minutes and 26 seconds	18 minutes	52 minutes and 2 seconds	40 minutes
Category 3			2 hours, 6 minutes and 56 seconds	2 hours
Category 4			3 hours, 22 minutes and 45 seconds	3 hours

Patient Transport Service

Our Patient Transport Service (PTS) is one of the largest ambulance providers of non-emergency transport in the UK.

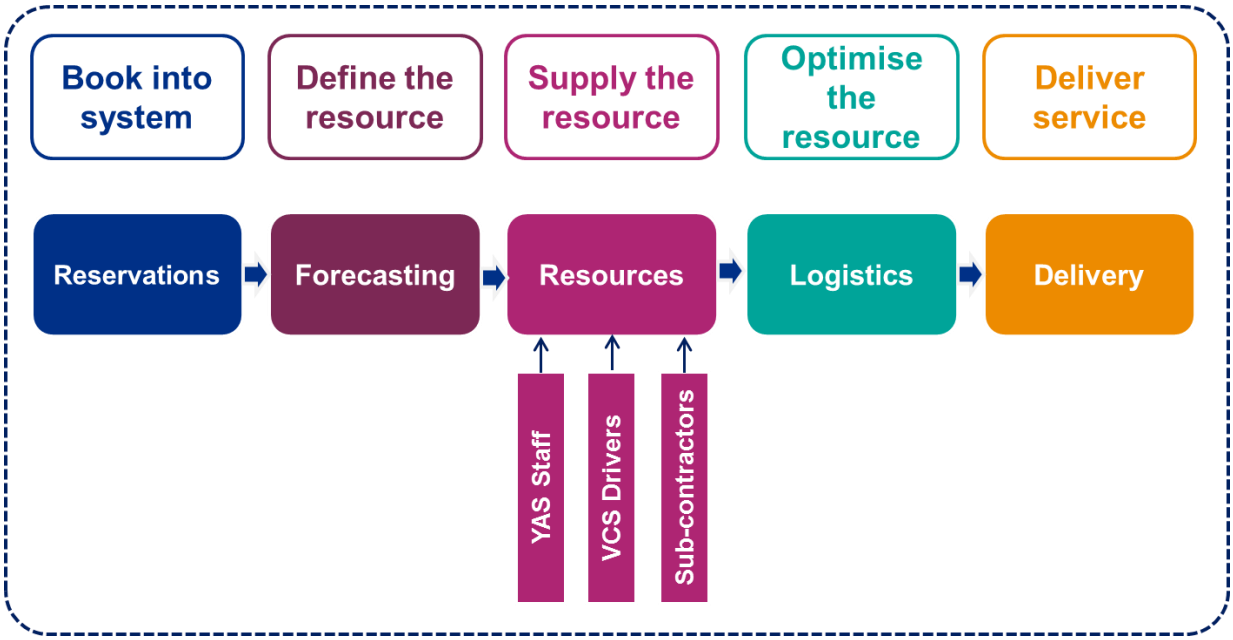
- Between April 2017 and March 2018 we undertook 944,403 patient journeys.
- Our Volunteer Car Service (VCS) completed 111,241 of those journeys and covered more than 2.1 million miles during the year.
- We use more than 60 sub-contractors who contribute to the successful delivery of our service in the most flexible manner. They delivered 17% of our journeys.

We provide transport for people who are unable to use public or other transport due to their medical condition and includes those:

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

Our non-emergency PTS provides much-needed support to patients and their carers and is an extremely important part of our service. Our PTS Operations Team is made up of over 550 staff who undertook 944,403 non-emergency journeys in 2017-18.

Our five-stage delivery model defines the way in which we manage each of our patient journeys in a bespoke yet efficient way. By utilising volunteers and experienced transport providers from the private sector, alongside specialist vehicles and highly-skilled staff within the Trust, we ensure that we have the capacity, flexibility and agility to meet the wide-ranging needs of our patients.



Our delivery model allows us to compete effectively against other providers in what is becoming an increasingly commercial environment. We believe that is the right thing for patients and the local healthcare community that patient journeys remain under the provision and governance of the NHS and we work closely with our commissioners to ensure that our service remains innovative and good value for money.

PTS Contracts

During 2017-18 we commenced two new five-year PTS contracts. The contract for non-emergency medical transport in the East Riding began on 1 July 2017 and the one for non-emergency health care PTS in South Yorkshire started on 1 September 2017.

In January 2018 YAS was awarded the contract for non-emergency ambulance transport for the Vale of York and Scarborough. The retention of this contract follows similar contract wins in South Yorkshire and the East Riding and underlines the significant improvements to service delivery and efficiency through the Trust's Patient Transport Service (PTS) Transformation Programme.

We were also successful in securing a two-year extension to the West Yorkshire contract from April 2017 to March 2019 and will be working collaboratively with commissioners over the next year on the design and specification of the future PTS in this area and the subsequent commercial tender.

Volunteer Car Service

Our Volunteer Car Service (VCS) provides an invaluable service supporting our PTS across the region, driving patients to and from medical appointments. Our team of VCS drivers has grown to 198 volunteers. This team covered a staggering 2,188,152 miles and carried out 111,241 patient journeys during 2017-18. This was a 40% increase on mileage in 2016-17 (1,553,900 miles) and a 66% increase on the number of journeys (70,014).

NHS 111 and Integrated Urgent Care

Demand and Performance
Our Yorkshire and Humber NHS 111 service, which serves a population of 5.3 million people, continues to experience a year-on-year growth in patient calls with 1,647,270 calls answered in 2017-18, a rise of 4.9% from the previous year.

Key performance information includes:

- 88.9% of calls answered within 60 seconds against a target of 95% (4.4% down compared to 2016-17).
- 82.5% of clinical calls received a call back within two hours; whilst this was a decrease from 2016-17, more calls are being managed by clinical staff.
- Of the calls answered, 9.0% were referred to 999, 15.1% were given self-care advice and 6.7% signposted to the emergency department (ED). The remainder were referred to attend a primary or community care service or attend another service such as dental.
- In an independent survey 95% of patients agreed/strongly agreed that they were treated with dignity and respect, with 96% of patients feeding back that they followed the advice that they were given. 90% would recommend NHS 111 to their friends and family as overall satisfaction for the service continues to be extremely positive with 48 compliments received.

NHS 111 Service Developments
2017-18 is the final year of the original five-year contract for NHS 111 and YAS has agreed with commissioners for a transitional year between 2018-19 prior to the formal re-procurement of the service from April 2019.

The publication of NHS England's Integrated Urgent Care (IUC) specification in August 2017 set out the national direction of travel for the development of urgent care services. More information about the specification can be found at https://www.england.nhs.uk/wp-content/uploads/2014/06/Integrated-Urgent-Care-Service-Specification.pdf

During the year YAS has worked with commissioners, sustainability and transformation partnerships (STPs) and A&E delivery boards to understand their ambitions for the future and to support the strategic direction of IUC for the Yorkshire and Humber region.

In particular the following service developments have been progressed during 2017-18 to support this way forward:

- Increasing the direct booking of patients into appointments within GP out-of-hours services in Rotherham, Hull and Sheffield.
- Making additional bookings into urgent care treatment centres and extended GP services.
- Increasing clinical advice to meet the 40% clinical advice NHS England target by December 2017, including additional emergency department (ED) referrals.
- Supporting the roll-out of the NHS Urgent Medicine Supply Advanced Service (NUSMAS) to support patients calling NHS 111 who need an urgent prescription.
- Working with NHS Digital, YAS has supported the roll-out of NHS 111 online services to West Yorkshire, North Yorkshire and the Humber areas in December 2017 following the successful pilot in Leeds earlier in the year.
- Clinical quality/quality developments - we continue to work with commissioners and suppliers including NHS Pathways to enhance service and referral pathways for patients calling NHS 111. During 2017-18 we successfully implemented two further upgrades to the clinical content of NHS Pathways with staff training on the new systems which included the Ambulance Response Programme (ARP) codes.

Some developments still underway include:

- pharmacy developments in line with the NHS England programme including the feasibility of introducing prescribing to support completing patient episodes
- supporting a national pilot of NHS Pathways distance-learning training to support the recruitment of part-time clinical staff who have other roles within the NHS and want to work part-time within NHS 111
- a staff support and development programme:
  - ***Team leader training and development programme:***
    - To develop a common training and development programme for both non-clinical and clinical team leaders. Giving team leaders the practical skills to do the job along with the emotional intelligence to support staff.
  - ***Mental health and wellbeing:***
    - To implement a package of health and wellbeing initiatives with four key products; mental health first aiders, Schwartz rounds, training including proactive stress assessments and focus weeks.
  - ***Staff recognition scheme:***
    - Updated and aligned with the new YAS vision, values and behavioural framework.
  - ***IUC workforce blueprint:***
    - Understanding the NHS England IUC workforce blueprint in relation to workforce strategy, feasibility of apprenticeships and continuous professional development for staff.
- working with our 999 Clinical Hub and reviewing integration opportunities and use of common technology, in particular the feasibility of the NHS Pathways Senior Clinician Module.

West Yorkshire Urgent Care

Our sub-contractor, Local Care Direct supported 258,685 patients during 2017-18, which is a 4.6% increase from the previous year. Ongoing developments are taking place across the patient pathway and wider transformational change will form part of the future development of urgent care across the health system in light of the IUC specification, primary care strategies with extended hours' schemes and links to local West Yorkshire STP ambitions.

Future Plans

The focus for NHS 111 in 2018-19 is to secure the service for YAS going forward. Commissioners are testing the market for a new contract starting in April 2019 to provide the integrated urgent care service for the region working with local providers and stakeholders working together to provide additional benefits for patients. Most notable is increasing the level of clinical advice through a virtual clinical advisory service, further enabling direct booking of onward care across the region and providing a 'consult and complete' model for our callers, supporting them to care for themselves at home.

Special Operations

Our Hazardous Area Response Team (HART) is part of the NHS contribution to the Government's National Capabilities Programme and part of the NHS contribution to the UK Counter Terrorism (CONTEST) strategy.

Its role is to provide NHS paramedic care to any patients within a hazardous or difficult-to-access environment that would otherwise be beyond the reach of NHS care. This includes the provision of clinical care within the inner cordon of incidents such as collapsed buildings or water-related locations.

Whilst being a locally-managed resource, is also a national asset and can be deployed anywhere in the UK to provide patient care wherever it is required. The YAS HART has 46 staff divided into seven teams operating 24/7. In 2017-18 the team responded to a wide range of incidents from single-patient incidents through to multiple casualties.

We provide clinical governance and clinicians to the Yorkshire Air Ambulance which operates 365 days a year. With new aircraft delivered during 2016 there are extend flying hours with night-flying operations. Each aircraft has a pilot and two YAS paramedics, with one of the aircraft also having a consultant-level doctor.

A brand new documentary series, *999 Rescue Squad,* was filmed during 2017-18 featuring the YAS HART. Initially broadcast on UKTV's W channel, the series has provided exclusive access to our HART and showcases the team as they race against time to rescue individuals in precarious and often life-threatening situations.

Filmed by Air Television Ltd – the producers of the successful *Helicopter ER* series featuring the work of the Yorkshire Air Ambulance – there were ten episodes in the initial broadcast period, with a second series already being filmed.

Mike Shanahan, Head of Special Operations, said: "I'm delighted that the work of our HART is being showcased in this exciting TV series.

"It's a fantastic opportunity to highlight how our highly trained paramedics work alongside their colleagues in Yorkshire Ambulance Service and the other emergency services in some of the most challenging situations.

"We're incredibly proud of the hard work put in by all our staff and volunteers to keep Yorkshire safe around the clock."

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

Fleet

During 2017-18 the Fleet Services Team focused on lowering our carbon emissions and the impact our vehicles have on the environment and 'make our blue lights green'. YAS was the first ambulance trust in the country to introduce electric-hydrogen vehicles into the fleet for use by its Support Services Team and we are working on a project to retrofit a diesel PTS vehicle with a hydrogen hybrid system.

Solar panels, used to charge the auxiliary power in the rear compartment of our new fleet of emergency ambulances, have also been rolled out. We also have an electric-petrol rapid response vehicle (RRV) on our fleet operating in the potential Leeds Clean Air Zone.

Our work has been recognised nationally with YAS a runner-up in the Innovation Award category at the Energy Saving Trust's Fleet Hero Awards 2017 which celebrated organisations that have implemented green solutions, policies and innovations to reduce their fleet's carbon footprint and fuel costs.

We were also awarded Best Public Sector Fleet of the Year (medium-large category) at the 2017 GreenFleet Awards for being a public sector organisation with a fleet of more than 300 vehicles that has demonstrated a reduction in CO_2 and other pollutants through fuel efficiency programmes, green fleet management and driver awareness training. In addition, Alexis Percival, our Environmental and Sustainability Manager, was awarded an EV Champion Award and was listed in the Top 100 Most Influential List 2017 list by GreenFleet magazine.

Technology

Electronic Patient Record (ePR)

A bespoke Electronic Patient Record (ePR) application has been developed by the in-house development team and is currently being used in a pilot programme in the South Yorkshire area. The application is based on a specification from frontline and clinical staff and reflects the content on the paper Patient Report Form.

Information, available to ambulance staff on route to an incident, starts the ePR record. Further information is added when a clinician is with the patient and at the destination hospital. There is the facility to record treatment and advice given if it is not necessary to take a patient to hospital.

The completed ePR is passed electronically to the hospital. Staff at Rotherham Hospital have been enthusiastic in their assistance with the pilot and have welcomed the content and clarity of the information.

The pilot is to be extended to other hospitals in the South Yorkshire area with a wider roll-out planned in 2018-19.

GP In-hours Direct Booking

GP in-hours direct booking is now live in 42 GP surgeries and provides technology to enable the NHS 111 call centre to book appointments directly with them.

NHS 111 Home Workers

ICT has enabled NHS 111 clinicians to work from home and provide full clinical advice service supported by virtual call centre technology. This has helped to improve the recruitment and retention of clinical staff to the NHS 111 service as it provides the flexibility to work from any location.

Auto-dialler
The new Auto-dialler solution will enable Trust to provide effective communications to all of our stakeholders without user intervention. Automated messages can be sent using voicemail, SMS, email or data with an acknowledgement from the recipient, received and logged. This is the most effective way to communicate during major incidents or cyber security attacks.

NHS Numbers
Access to patients' NHS numbers has been implemented for the 999 and PTS call centres. This provides staff with the ability to retrieve NHS numbers for patients through the NHS Spine.

Collaborative Projects

National Ambulance LGBT network
We worked with the National Ambulance LGBT Network on the design and build of their new website, including social media channels and other marketing materials – www.ambulancelgbt.org

Commercial Services

Learning Technology Support Service
We have secured and maintained a commercial contract serving more than 90 NHS trusts across the north of England in the delivery of their e-learning and other learning technology services.

Partnership Working

Community Engagement and Public Education

YAS has over 8,000 public members that we are confident are representative of the diverse local population which makes up the Trust's extensive geographical area. We are keen for our members to act as ambassadors for the Trust and engage with local communities in raising awareness of how to access our services; 999, NHS 111 and the non-emergency Patient Transport Service (PTS) as well as highlighting topical public health issues.

The Trust held a series of roadshows across Yorkshire and Humber which provided members of the public with an opportunity to learn more about the ambulance service's wider role in the health, emergency and voluntary sectors, free first aid training, and about possible careers and volunteering opportunities with us. Events were held in Sheffield, Bradford, Scarborough, Leeds and Hull.

More than 100 people attended a community fun day at the Pakistan Muslim Centre (PMC) in Sheffield where representatives from Sheffield Hallam University joined us to give information about the paramedic science degree they provide. The day also involved free first aid awareness training including life-saving CPR demonstrations. The event was attended by Imam Sheikh Mohammed Ismail, Deputy Lord Lieutenant of Sheffield, Councillor Anne Murphy and the Right Worshipful the Lord Mayor of Sheffield.

Chairman Muhammad Ali of the Pakistan Muslim Centre, said: "I was absolutely delighted to host the engagement event at the PMC in Darnall. I have received lots of positive feedback from community members thanking Yorkshire Ambulance Service for organising a highly informative and successful event."

Working in partnership with NEESIE, a voluntary organisation for single mothers, the Trust held a community family fun day at the Carlisle Business Centre in Bradford. Residents were invited to come along to the free event, take part in free first aid awareness training and receive advice and guidance on careers and volunteering roles within the Trust.

The event was attended by Stan Hardy, Deputy Lord Lieutenant of West Yorkshire, and Councillor Abid Hussain, Lord Mayor of Bradford.

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

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

If you would like to nominate your society or local community group for a free first aid awareness training session please email yas.membership@nhs.net with details.

Sharing Best Practice

Working collaboratively with other ambulance services and our emergency services' partners is important to sharing best practice and working more efficiently and effectively.

The **Northern Ambulance Alliance (NAA)** is a collaboration with our neighbouring ambulance services (North East, North West and now East Midlands as an associate member). During the year we have seen a number of successful collaborative initiatives in fleet, procurement and clinical support. Efforts to align collective back-office functions also saw YAS's Payroll Team take on responsibility for the administration of North East Ambulance Service's payroll in February 2018.

The **West Yorkshire Tri-Services Collaboration Board** has brought together emergency services across West Yorkshire, including YAS, who have agreed to explore an overall programme of collaborative work. The focus of tri-service collaboration is initially around the support functions and roles that that could potentially come together and work as one across the three services.

The Trust is also a member of the **Association of Ambulance Chief Executives (AACE)** which provides ambulance services with a central organisation that supports, coordinates and implements nationally agreed policy. It also provides the general public and other stakeholders with a central resource of information about NHS ambulance services.

YAS had two national award winners at this year's AACE Ambulance Leadership Forum (ALF) Awards. Dave Hill, Ancillary Services Manager, won the Outstanding Service in Support Services Award and Alistair Gunn, Planning and Development Manager, won the Outstanding Service in Leading on Diversity and Inclusion for his work with the YAS Lesbian, Gay, Bisexual and Transgender (LGBT) Network and National Ambulance LGBT Network.

Community Resilience

Community First Responders

Our Community First Responder (CFR) scheme is a partnership between the Trust and groups of volunteers who are trained to respond to life-threatening emergencies such as breathing problems, chest pain, cardiac arrest and stroke.

We have 948 CFRs who belong to 340 CFR teams across Yorkshire and the Humber. In addition, we work with 48 co-responders in 21 teams which include fire and rescue services, Coastguard and Mountain Rescue.

In 2017-18, they responded to 16,320 calls, including 3,170 Category 1 incidents. They were first on scene at 1,381 of those Category 1 incidents and attended 804 cardiac arrests.

CFRs were involved in 49 incidents where a Return of Spontaneous Circulation (ROSC) was achieved, with 16 patients being discharged from hospital after surviving a cardiac arrest in the first half of the year.

The total number of on-call hours provided by CFRs was 307,962, which is equivalent to 7,700 40-hour working weeks. They have also supported the Tour de Yorkshire by providing first aid cover along the race route and volunteered to provide cardiopulmonary resuscitation (CPR) training as part of Restart a Heart Day.

In the last year, CFRs have been trained to use pulse oximeters to measure the amount of oxygen in a patient's blood. This helps them to provide effective treatment and also provide more information to ambulance clinicians when handing over patients.

Community Defibrillators and CPR Awareness

There are 2,635 static defibrillator sites at places such as airports, railway stations, shopping centres, GP and dental practices and police custody suites. There are also 1,303 community Public Access Defibrillator (cPAD) sites which are available 24/7, 365 days a year.

We are continually working with clinical commissioning groups (CCGs), local councils and fundraising groups to install more cPADs in communities across the region. We also work alongside the Yorkshire Ambulance Service Charity to deliver cPAD awareness where successful grant applications have been made.

In January 2018, the Sheffield Pulsepoints project was launched to install 12 new cPADs in and around the city centre, including street signs directing people to their nearest cPAD. The initiative, which follows the deaths of two men who suffered a cardiac arrest in 2017, is a partnership between the Community Resilience Team, Sheffield Business Improvement District, Westfield Health Charitable Trust and city centre businesses. It has received widespread media attention, including a BBC Radio Sheffield video showing how to use an automated external defibrillator (AED), which has had more than 570,000 views.

Hands-only CPR training has been delivered to 31,933 people since January 2013. Hundreds of YAS staff and volunteers also trained more than 25,000 youngsters how to perform CPR during Restart a Heart Day on 16 October 2017.

Awards

YAS *WE CARE Awards*

- CFR and volunteer car driver Dean Warburton won Volunteer of the Year.
- CFR John Ibbotson was highly commended in the same category.
- Community Defibrillation Trainer Ben Rushworth was highly commended in the Always Compassionate category.

The Community Resilience Team was shortlisted for Community First Responder Scheme of the Year and Emergency Services Team of the Year at the 2017 Heart Safe Awards. CFR Rachel Hallas won Lifesaver of the Year Award at the same event.

South Yorkshire CFR Dan Maude won Young Volunteer of Year at the 2017 Rotherham Community Achievement Awards.

The Leeds Medical Students CFR scheme won Best Outreach and Engagement at the 2018 Worsley Society Awards.

The Thirsk CFR scheme won the Emergency Services Award at Minster FM’s 2018 Local Hero Awards.

Other notable events during the year included:

- A new initiative launched with West Yorkshire Police firearms officers attending cardiac arrest incidents. There were 40 activations which resulted in five ROSCs from 5 September 2017 to 1 January 2018.
- The Hull Horseshoe project is developing new CFR schemes in East Yorkshire.
- The Community Resilience Team gained ISO accreditation for Business Continuity.

Ambitions for 2018-19

- Recruit new volunteers with the aim of having 1,100 CFRs and an additional 25 schemes by the end of 2018-19.

- As well as recruiting and retaining CFRs, we aim to be able to increase the number of hours they contribute from four hours to seven hours per week (CFRs gave 307,962 hours in 2017-18).
- Increase activity by 5% and further contribute to Trust performance on responding to Category 1 calls.
- In conjunction with CCGs, parish councils and community groups, we aim to increase the number of cPAD sites by a further 10% so our ambition is to place an additional 129 devices.
- Introduce a new structure to provide a seamless career pathway for the Community Resilience Team.
- Provide trackable devices for all CFR schemes.
- Explore new initiatives on urgent and social care issues which volunteers could support.
- Training all volunteers in the use of the national early warning score (NEWS).
- Continue to support the Restart a Heart initiative to 11-16 year-olds.

Yorkshire Ambulance Service Charity

Yorkshire Ambulance Service (YAS) has its own charity which receives donations and legacies from grateful patients, members of the public and fundraising initiatives throughout Yorkshire.

The YAS Charity exists to help to save more lives across Yorkshire through funding projects which enable **everyone** to respond appropriately in a medical emergency. It also funds health and wellbeing initiatives for YAS colleagues who deal with such emergencies every day.

Yorkshire Ambulance Service NHS Trust is the Charity's trustee and 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 independently from our public funding by administering them through a separate Charity Committee.

During 2017-18 the Charity has been refocusing its purpose and working hard to increase its external profile. It has continued to work in partnership with local communities to part-fund community public access defibrillators across the region and over 60 have been purchased during the year.

The YAS Charity once again supported our Restart a Heart Day campaign which saw over 25,000 youngsters receive cardiopulmonary resuscitation (CPR) training on 18 October 2017 and purchased 500 manikins for on-going training purposes.

It also continued to fund the work of the community engagement trainer who provides vital life-saving training to local groups across Yorkshire.

Make a Donation

If you would like to make a donation or support the YAS Charity:

- Visit www.yascharity.org.uk
- Phone 01924 584369

www.facebook.com/YASCF
www.twitter.com/YAS_Charity

Registered Charity* ***No.1114106*

How We Work

Openness and Accountability Statement

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

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

We hold a Trust Board meeting in public every quarter and our Annual General Meeting is held in September each year. These are open to members of the public.

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

If you have used our services and have a compliment, complaint or query, please do not hesitate to contact us, email 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.

Environmental Policy

Yorkshire Ambulance Service has long strived to 'green' its operations. We aim to ensure that our buildings, fleet and all goods and services we buy are manufactured, delivered, used and managed at the end of their useful life in an environmentally and socially acceptable way. YAS is committed to reducing the carbon footprint of its buildings, fleet and staff whilst not compromising the core work of our services, patient care.

The Trust has an Environmental Policy in place to ensure the reduction of its actions on the environment. The Trust's Carbon Management Plan, which is consistent with local and national healthcare strategies, sets out our long-term commitment to sustainable reductions of our CO_2 emissions and carbon footprint. This report is annually updated and the plan identifies CO_2 savings to be made within Estates, IT, Procurement and Fleet departments.

We anticipate the impacts of future policy and legislation and position ourselves to maximise the sustainability benefits to our organisation. We have a process of horizon scanning for best practice, changes to mandatory and legislative drivers and adopt early to maximise benefits.

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

Looking Forward to 2018-19

The year ahead is set to be an exciting time for new fleet additions. Yorkshire Ambulance Service was the first ambulance service in the country to have hydrogen electric powered vehicles on their support vehicle fleet. In 2018-19, through funding from Innovate UK, we will be converting and running one of our Patient Transport Service vehicles as hydrogen diesel retrofit.

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

We are looking to roll out more solar panels on our buildings, install more bike racks, implement travel plans to reduce our impact from single-use vehicles, have a more efficient fleet and ensure that we continue to reduce our carbon footprint through a variety of different initiatives. The remodelling of Doncaster Ambulance Station into the Trust's first 'Hub' should achieve a high BREEAM standard when completed for the green credentials installed.

We are also looking to roll out electric charging points at our stations to make our stations ready for zero emission or hybrid vehicles to join the fleet.

YAS Sustainability Report 2017-18

Yorkshire Ambulance Service was the first ambulance service in the country to draw up a Carbon Management Plan (now identified as the Sustainable Development Management Plan (SDMP)), identifying the areas in which we can reduce our carbon footprint. The NHS Sustainable Development Unit (SDU), along with colleagues from the Department of Health, has developed a standard reporting template for NHS organisations which form the basis for their Sustainability Report (SR). This is in line with data requirements in the HM Treasury's Financial Reporting Manual.

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

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

- We installed solar panels on our new fleet of double-crewed ambulances which trickle charge batteries to reduce the impact of idling.
- We have stopped sending waste to landfill (a small amount is still produced as 'flock' from incineration) and are working to reduce the amount of waste that we generate through more paperless operations and returning waste to the suppliers. Waste diverted from landfill now goes to recovery for fuel.
- We have rolled out waterless urinals at our headquarters.
- We have five sites that have solar generation systems installed on their roofs.
- We have installed LED lighting panels at many of our sites in order to reduce our energy use.
- We have three hydrogen hybrid vehicles on our fleet in 2018; the first ambulance service in the country to have vehicles of this type.
- Yorkshire Ambulance Service has also been instrumental in driving forward an aerodynamic lightweight ambulance design. The first redesigned ambulances were introduced into the fleet in 2014. Aerodynamic designs have been adopted nationally into the procurement requirements.
- Our staff energy reduction and fuel awareness campaign is ongoing throughout 2018-19.
- NHS organisations have a statutory duty to assess the risk posed by climate change and the Trust is considering the potential need to adapt the organisation's activities, buildings and estates in line with this policy. This will pose a challenge to both service delivery and infrastructure in the future. YAS has a Climate Change Adaptation Plan to look to the challenges we face into the future.
- Sustainability issues are included in the Trust's analysis of risks facing the organisation. Risk assessments, including the quantification and prioritisation of risk, are an important part of managing complex organisations.
- The Trust has a Sustainable Transport Plan, which considers what steps are needed and are appropriate to reduce or change travel patterns. Travel plans are in place for several sites across the organisation, working to reduce single occupancy car use.

Information Governance

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

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

The Senior Information Risk Owner (SIRO) during 2017-18 was Steve Page, Executive Director of Governance, Quality and Performance Assurance. The SIRO is a senior management board member who takes overall ownership of the organisation's information risk policy, acts as the champion for information risk on the Board and provides written advice to the Accountable Officer on the content of the organisation's Governance Statement for information risk.

The Caldicott Guardian during 2017-18 was Dr Julian Mark, Executive Medical Director. A Caldicott Guardian is a senior person responsible for the protection of the confidentiality of patient and service-user information and appropriate information-sharing.

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

A total of 35 Information Governance Toolkit requirements support the provision of good information governance within the Trust. Over the past five financial years the Trust has increased its self-assessment submission score by 12% to a score of 85% (rated 'satisfactory' against a satisfactory/unsatisfactory rating regime).

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

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

Serious Incidents Requiring Investigation

During 2017-18 there were two personal data-related incidents that met the Information Governance Serious Incidents Requiring Investigation (IG SIRI) criteria at Level 2 severity or above (the summary of these incidents can be seen below). Such incidents require reporting to the Information Commissioner's Office, Department of Health and other regulators as well as detailing within NHS Trust annual reports.

A summary of the two incidents reported during 2017-18:

- As a result of remedial action to rectify access permissions to the HR network drive all files within the drive inadvertently became available to all YAS staff internally for a short period of time.

- The Trust created a folder on the network drive so that staff can temporarily collaborate with records that they would not normally have joint access to. It was found that staff had saved files in this folder which contained personally identifiable information and that these files remained in the folder after the collaboration had taken place.

Both incidents were formally investigated using the Trust's established serious incident investigation procedures. Recommendations for changes and improvements to existing operational practices have been made as part of this process. To date, the Trust has received an outcome for the first of the SIRI incidents, where no further action was required apart from completion of the Trust's internal action plan. The Trust awaits the outcome of the remaining SIRI incident. The Trust will continue to monitor its information-related risks in order to identify and address any risks and ensure continuous improvement of its information governance arrangements.

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

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

Table 1: Summary of other personal data-related incidents in 2017-18

Category	*Breach Type*	*Total*
A	Corruption or inability to recover electronic data	2
B	Disclosed in error	32
C	Lost in transit	3
D	Lost or stolen hardware	1
E	Lost or stolen paperwork	26
F	Non-secure disposal - hardware	0
G	Non-secure disposal - paperwork	0
H	Uploaded to website in error	0
I	Technical security failing	4
J	Unauthorised access/disclosure	10
K	Other	21

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

Our local contact for reporting potential fraudulent activity or obtaining advice is via Audit One, Kirkstone Villa, Lanchester Road Hospital, Durham, DH1 5RD, https://www.audit-one.co.uk/

Going Concern Statement

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

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

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

Signed: 

Rod Barnes, Chief Executive 24 May 2018

Accountability Report

The Board of Directors 2017-18

(with headshots)

Chairman
Kathryn Lavery

Chief Executive
Rod Barnes

Executive Director of Finance
Mark Bradley

Executive Director of Quality, Governance and Performance Assurance (previously Executive Director of Standards and Compliance) and Deputy Chief Executive
Steve Page

Executive Medical Director
Dr Julian Mark

Executive Director of Operations
Dr David Macklin

Director of Workforce and Organisational Development
Roberta Barker (Interim) (from 1 February 2016 until 30 June 2017)
Christine Brereton (from 1 November 2017)

Director of Urgent Care and Integration (formerly Director of Planning and Development)
Leaf Mobbs

Director of Planned and Urgent Care
Dr Philip Foster (until 31 October 2017)

Non-Executive Directors
Patricia Drake (until 31 March 2018)
Erfana Mahmood
Barrie Senior (until 30 November 2017)
John Nutton
Ronnie Coutts
Phil Storr (Associate)
Tim Gilpin (Associate)
Richard Keighley (from 1 February 2018)

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 of Directors and Committee Membership 2017-18

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

Committee	
Quality Committee	Three Non-Executive Directors Executive Director of Quality, Governance and Performance Assurance Executive Medical Director Director of Workforce and Organisational Development Executive Director of Operations Director of Urgent Care and Integration
Audit Committee	Three Non-Executive Directors including Chairpersons of the Quality and Finance and Investment Committees
Finance and Investment Committee	Three Non-Executive Directors Chief Executive Executive Director of Finance Executive Director of Operations Director of Planning and Development
Charity Committee	Two Non-Executive Directors Executive Director of Finance (or Head of Financial Services) Trust Secretary Fund Manager Head of Corporate Communications
Remuneration Committee	Chairman and all Non-Executive Directors

Declaration of Interests for the Financial Year 2017-18

Name/Dates	Paid / Unpaid Employment	Directorships of Commercial Companies	Shareholdings	Elected Office	Trusteeships or participation in the management of charities and other voluntary bodies	Public Appointments (paid or unpaid)	Membership of professional bodies/trade association or bodies
NON-EXECUTIVE DIRECTORS (NEDs)							
Kathryn Lavery **Chairman** **1 July 2016**	Non-Executive Director Navigo, North East Lincolnshire Consultant to Hull University (retained contract)	Director Kath Lavery Associates	None	None	Trustee of YAS Charity Chairman of Hull Kingston Rovers Community Trust Chairman of Humber Business Week Chairman of Athena Aspire Ltd.	None	Fellow of Institute of Directors

Ronnie Coutts **25 October 2016**	Serco Ltd.	None	None	None	Trustee of YAS Charity Trustee of the Alexander Fairey Memorial Fund Charity No: 10704088	None	None
Patricia Drake **Deputy Chairman/NED** **4 October 2010 until 31 March 2018** **(Interim Chairman from 10 May 2016 to 30 June 2016)**	Specialist Advisor Care Quality Commission (CQC)	None	None	None	Trustee of YAS Charity	Justice of the Peace Governor of Calderdale College	Royal College of Nursing

Name/Dates	Paid / Unpaid Employment	Directorships of Commercial Companies	Shareholdings	Elected Office	Trusteeships or participation in the management of charities and other voluntary bodies	Public Appointments (paid or unpaid)	Membership of professional bodies/trade association or similar bodies
NON-EXECUTIVE DIRECTORS							
Barrie Senior **NED** **16 August 2012 until 30 November 2017**	Self Employed (NED), AHR Management Services Self Employed Partner, Senior Associates LLP	None	None	None	Trustee of YAS Charity	None	Fellow of Institute of Chartered Accountants in England & Wales
Richard Keighley **NED** **1 February 2018**	None	Portfolio FD Services Ltd.		None	Trustee of YAS Charity Non-Executive Director, Athena Aspire Ltd.	None	Fellow of Institute of Chartered Accountants in England & Wales
Erfana Mahmood **NED**	Chorley and District Building Society	Chorley and District Building Society Non-Executive	None	None	Trustee of YAS Charity	None	Member of Law Society

15 May 2012	Walker Morris	Director, Plexus and Omega Housing (subsidiary of Mears Group Plc)					
John Nutton NED **5 June 2015**	Self-employed Corporate Finance practitioner, Springwell Corporate Finance in association with Cattaneo LLP	The Carbis Beach Apartments Management Company Limited	None	None	Trustee of YAS Charity Member of The Wakefield Grammar School Foundation Clayton Hospital Site Fund Raising Committee Member of the Wakefield Cathedral Friends Committee	None	Fellow of Institute of Chartered Accountants in England & Wales
Name/Dates	**Paid / Unpaid Employment**	**Directorships of Commercial Companies**	**Shareholdings**	**Elected Office**	**Trusteeships or participation in the management of charities and other voluntary bodies**	**Public Appointments (paid or unpaid)**	**Membership of professional bodies/trade association or similar bodies**

CHIEF EXECUTIVE OFFICE AND EXECUTIVE DIRECTORS							
Rod Barnes Chief Executive **6 May 2015**	None	None	None	None	Trustee of YAS Charity	CEO Lead Northern Ambulance Alliance Chairman of the Finance Advisory Board NHS Improvement Ambulance Sustainability Review Member of the Ambulance Improvement Programme NHSE/NHSI Care Quality Commission Well Led Reviewer	Chartered Institute of Management Accountants Healthcare Financial Management Association (HFMA)
Mark Bradley Executive Director of Finance	None	None	None	None	Trustee of YAS Charity	None	Chartered Institute of Management Accountants

1 March 2017							Healthcare Financial Management Association (HFMA)
Name/Dates	**Paid / Unpaid Employment** ***(specify)***	**Directorships of Commercial Companies**	**Shareholdings**	**Elected Office**	**Trusteeships or participation in the management of charities and other voluntary bodies**	**Public Appointments (paid or unpaid)**	**Membership of professional bodies/trade association or similar bodies**
CHIEF EXECUTIVE OFFICE AND EXECUTIVE DIRECTORS							
Christine Brereton Director of Workforce and Organisational Development **1 Nov 2017**	None	None	None	None	Trustee of YAS Charity	None	Fellow Member of Chartered Institute of Personnel and Development (CIPD)
Dr David Macklin	None	None	None	None	Trustee of YAS	Associate Tutor, Emergency	British Medical

Executive Director of Operations **7 May 2015**					Charity Medical Director, Yorkshire Air Ambulance Charity	Services Training Centre, Wirral Board Member, NHS Pathways Programme Board, HSCIC	Association Fellow Institute of Civil Protection & Emergency Management Faculty of Pre Hospital Care of the Royal College of Surgeons of Edinburgh British Association of Immediate Care Schemes Medical Protection Society Faculty of Medical Leadership and Management

Name/Dates	Paid / Unpaid Employment	Directorships of Commercial Companies	Shareholdings	Elected Office	Trusteeships or participation in the management of charities and other voluntary bodies	Public Appointments (paid or unpaid)	Membership of professional bodies/trade association or similar bodies
CHIEF EXECUTIVE OFFICE AND EXECUTIVE DIRECTORS							
Dr Julian Mark Executive Medical Director **1 October 2013**	*Unpaid:* Good Governance Institute: development of a white paper on population health management sponsored by IBM (From Dec 2017 to Jan 2018)	None	None	None	Trustee of YAS Charity	Chair National Ambulance Service Medical Directors (NASMeD) Board Member Faculty of Pre Hospital Care of the Royal College of Surgeons of Edinburgh Member of NHS Improvement Clinical Advisory Forum	Faculty of Pre Hospital Care of the Royal College of Surgeons of Edinburgh British Association of Immediate Care Schemes Medical Protection Society Faculty of Medical Leadership and Management

Steve Page Executive Director of Quality, Governance and Performance Assurance (previously titled Standards and Compliance) **1 October 2009**	None	None	None	None	Trustee of YAS Charity	Care Quality Commission Well Led Reviewer	Nursing & Midwifery Council Registration
Name/Dates	**Paid / Unpaid Employment**	**Directorships of Commercial Companies**	**Shareholdings**	**Elected Office**	**Trusteeships or participation in the management of charities and other voluntary bodies**	**Public Appointments (paid or unpaid)**	**Membership of professional bodies/trade association or similar bodies**
ASSOCIATE NON-EXECUTIVE DIRECTORS							
Tim Gilpin 31 Jan 2017	None	Managing Director of TGHR Ltd.	None	None	None	School Governor, Dixons Multi Academy Trust	Member of Chartered Institute of Personnel and Development (CIPD)
Phil Storr	MRL Safety Limited (including a	MRL Safety Ltd.	None	Vice-Chair, Burn	None	Visiting Lecturer, Loughborough	Associate – Emergency Planning Society

31 Jan 2017	contract with NECSU/NHS IMAS providing operational management support to NHS England Midlands & East Region)	Medical Response Logistics Ltd. MRL Eye Ltd. MRL Environmental Ltd. Burn Grange Properties Ltd.		Parish Council		University Visiting Lecturer, Bournemouth University Associate Lecturer – Emergency Planning College	Health & Care Professions Council (HCPC) Member of the Federation of Small Businesses Member of NHS Interim Management & Support Service (NHS IMAS)
NON-VOTING DIRECTORS (OFFICERS)							
Name/Dates	**Paid / Unpaid Employment**	**Directorships of Commercial Companies**	**Shareholdings**	**Elected Office**	**Trusteeships or participation in the management of charities and other voluntary bodies**	**Public Appointments (paid or unpaid)**	**Membership of professional bodies/trade association or similar bodies**
Leaf Mobbs Director of Urgent	None	None	None	None	Trustee of YAS Charity	None	None

Care and Integration (from 1 Nov 2017) (formerly Director of Planning and Development until 31 Oct 2017) **13 June 2016**							

Name/Dates	Paid / Unpaid Employment	Directorships of Commercial Companies	Shareholdings	Elected Office	Trusteeships or participation in the management of charities and other voluntary bodies	Public Appointments (paid or unpaid)	Membership of professional bodies/trade association or similar bodies
ARCHIVED INTERESTS: **NON-EXECUTIVE AND EXECUTIVE / NON-VOTING DIRECTORS**							
Roberta Barker Director of Workforce and Organisational Development (Interim) **1 February 2016** **until 30 June 2017**	None	Director of J&L People Ltd		None	None	None	Member of Chartered Institute of Personnel and Development (CIPD)
Dr Philip Foster Director of Planned and Urgent Care **6 May 2016 until 31 October 2017**	Sessional work at Bassetlaw Hospice	None	None	None	Trustee of YAS Charity Trustee of Aurora Charity, Bassetlaw	None	British Medical Association MDDUS Association for Palliative Medicine

Remuneration and Staff Report

Remuneration Policy

All permanent Executive Directors are appointed by the Trust through an open recruitment process. All have substantive contracts and have annual appraisals. Executive Director salaries are determined following comparison with similar posts in the NHS and wider public sector and are approved by the Remuneration Committee, a sub-committee of YAS's Board of Directors and which, under current arrangements for ambulance services, requires the approval of NHS Improvement **(NHSI).**

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

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

The Chairman and all the Non-Executive Directors have served as members of the Committee during the year. It meets regularly to review all aspects of pay and terms of service for Executive Directors and VSMs.

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

Salaries and Allowances of Senior Managers 2017-18

These tables have been subject to audit. Note: There are no disclosures in respect of performance pay or bonuses as the Trust makes no payments of these types.

Salaries and Allowances of Senior Managers 2017-18

Name and title	Notes	2017-18				2016-17			
		(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100*	(c) All pension-related benefits (bands of £2,500)	(d) TOTAL (a to c) (bands of £5,000)	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100*	(c) All pension-related benefits (bands of £2,500)	(d) TOTAL (a to c) (bands of £5,000)
		£000	£00	£000	£000	£000	£00	£000	£000
Rod Barnes Chief Executive		130-135	77	40-42.5	180-185	130-135	70	30-32.5	165-170
Mark Bradley Executive Director of Finance		120-125	-	32.5-35	155-160	10-15	-	77.5-80	85-90
Robert Toole Executive Director of Finance and Performance (Interim)	1					175-180	-	-	175-180
Dr David Macklin Executive Director of		115-120	33	30-32.5	150-155	110-115	67	25-27.5	145-150

Operations									
Dr Julian Mark Executive Medical Director		125-130	-	35-37.5	165-170	125-130	-	27.5-30	155-160
Steve Page Deputy Chief Executive (see note)	2	105-110	71	25-27.5	135-140	105-110	65	15-17.5	125-130
Christine Brereton Director of Workforce and Organisational Development	3	45-50	-	32.5-35	75-80	-	-	-	-
Roberta Barker Director of Workforce and Organisational Development (interim)	4	25-30	-	-	25-30	135-140	-	-	135-140
Leaf Mobbs Director of Urgent Care and Integration (formerly Director of Planning and Development)	5	100-105	-	35-37.5	140-145	80-85	-	50-52.5	130-135
Dr Phil Foster Director for Planned and Urgent Care	6	70-75	-	-	70-75	115-120	-	-	115-120
Patricia Drake Deputy Chairman and Non-Executive Director		5-10	-	-	5-10	5-10	-	-	5-10
Kathryn Lavery Chairman		35-40	-	-	35-40	25-30	-	-	25-30
Della Cannings QPM Chairman	7	-	-	-	-	0-5	-	-	0-5

Erfana Mahmood Non-Executive Director		5-10	-	-	5-10	5-10	-	-	5-10
Barry Senior Non-Executive Director	8	0-5	-	-	0-5	5-10	-	-	5-10
Ronnie Coutts Non-Executive Director		5-10	-	-	5-10	5-10	-	-	5-10
John Nutton Non-Executive Director		5-10	-	-	5-10	5-10	-	-	5-10
Richard Keighley Non-Executive Director	9	0-5	-	-	0-5	-	-	-	-
Phil Storr Associate Non-Executive Director		5-10	-	-	5-10	0-5	-	-	0-5
Tim Gilpin Associate Non-Executive Director		5-10	-	-	5-10	0-5	-	-	0-5
Mary Wareing Non-Executive Director	10	-	-	-	-	0-5	-	-	0-5

1 To 28 February 2017
2 Also Executive Director of Quality, Governance and Performance Assurance. Deputy Chief Executive from 22 February 2018.
3 From 1 November 2017
4 To 30 June 2017
5 From 1 November 2017. Director of Planning and Development to 31 October 2017.
6 To 31 October 2017
7 To 9 May 2016
8 To 31 December 2017
9 From 1 February 2018
10 To 31 August 2016

Pension Entitlement Table 2017-18

These tables have been subject to audit

	Notes	(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 31st March 2018 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31st March 2018 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1st April 2017	(f) Real increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31st March 2018	(h) Employer's contribution to stakeholder pension	(i) All pension-related benefits (bands of £2,500)
Name and title		**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Rod Barnes Chief Executive		2.5-5	0-2.5	45-50	115-120	722	61	802	19	40-42.5
Mark Bradley Executive Director of Finance		0-2.5	5-7.5	30-35	90-95	492	52	561	17	32.5-35
Dr David Macklin Executive Director of Operations		0-2.5	0-2.5	25-30	55-60	285	27	329	16	30-32.5

Dr Julian Mark Executive Medical Director		2.5-5	0-2.5	35-40	90-95	548	48	613	18	35-37.5
Steve Page Deputy Chief Executive	1	0-2.5	5-7.5	45-50	135-140	894	71	981	15	25-27.5
Christine Brereton Director of Workforce and Organisational Development	2	0-2.5	-	0-5	-	26	15	47	6	32.5-35
Leaf Mobbs Director of Urgent Care and Integration	3	2.5-5	0-2.5	25-30	55-60	338	36	388	15	35-37.5
Roberta Barker Director of Workforce and Organisational Development (interim)	4	Has opted out of Trust Pension Scheme								
Dr Phil Foster Director for Planned and Urgent Care	5	Has opted out of Trust Pension Scheme								

Notes

1 Also Executive Director of Quality, Governance and Performance Assurance. Deputy Chief Executive from 22 February 2018.
2 From 1 November 2017
3 From 1 November 2017. Director of Planning and Development to 31 October 2017.
4 To 30 June 2017
5 To 31 October 2017

Fair Pay Disclosure 2017-18

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

The banded remuneration of the highest paid director/member in the Trust in the financial year 2017-18 was £130,000-£135,000 (2016-17, £175,000 - £180,000) This is 5.17 times (2016-17, 7.11 times) the median remuneration of the workforce, which was £25,446 (2016-17, £25,039). No employees (2016-17, no employees) received remuneration in excess of the highest-paid director/member. Remuneration ranged from £6,848 to £131,464 (2016-17, £6,355 to £178,072).

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

The highest paid director/member has changed from 2016-17 as roles previously filled by temporary contracts have been replaced by permanent employees.

Our Staff

Our workforce is central to achieving our vision “To be trusted as the best urgent and emergency care provider, with the best people and partnerships, delivering the best outcomes for patients”. We cannot achieve this without a fully engaged, well-trained and committed workforce and we endeavour to support and involve our staff in order to ensure that they can flourish and have the ability and confidence to provide the very best care for our patients.

Organisational Development
We launched a new set of values and behaviours in 2017-18 and we expect all our staff to live these values in their everyday working lives. Our Board of Directors is committed to ensuring that the values and associated behavioural framework are an integral part of everything we do and we have a clear implementation plan to embed our values through our daily business.

The *Living our Values* programme has now been established and work-stream leads are defining the purpose and objectives of their project/s in order to progress with changes and improvements. These actions will essentially support the Trust in embedding the new values and behaviours into working practices to support a fundamental and positive shift in culture.

We are proud of our new values and behavioural framework and will use these as a clear focus when developing our leaders and managers.

We also established a new Strategic Workforce Group during 2017-18 and our journey of organisational development will be governed through this group that is chaired by the Director of Workforce and Organisational Development.

Diversity and Inclusion
We are committed to ensuring that there is equality of opportunity for all our staff, patients, and stakeholders.

By achieving this patients will receive improved care and a better experience from consistently getting the right response, in the right place, first time and in time.

We provide high quality care and need to continue to match our services to the changes in healthcare provision and the increasing demands of the public. At the same time we must develop our workforce to ensure that it reflects the needs of communities which it serves. We want to ensure we have a better knowledge and understanding of those communities, and are therefore better able to meet the needs of our service users and patients.

Tackling discrimination and harassment, promoting equality of opportunity and maintaining good community relations are central to all we do across the organisation. We have therefore adopted a mainstream approach in the way we work and how we develop our staff.

We recognise that equality and diversity is part of our core business with regard to:

- achieving corporate objectives
- tackling health inequalities and meeting local priorities
- securing a diverse workforce
- providing culturally competent services
- having patient and public involvement
- promoting the social inclusion agenda.

The Trust's Diversity and Inclusion Strategy, 'Embracing Diversity – Promoting Inclusivity' was launched in December 2017. The strategy sets out the principles and actions by which the Trust intends to achieve its newly developed mandate as well as meeting legal and contractual obligations.

In addition, we want to be the employer of choice for all our current and prospective staff and a provider of great care for our patients. We are seeking to go beyond mere compliance with standards and the law and so we have developed a strategy which, at its heart, has ambitions for our patients and staff not because it 'must be done' but because it is the right thing to do.

The Diversity and Inclusion Strategy applies to everyone who visits or works at any of our sites, users of our services, patients and communities, regardless of race or ethnicity, sex, gender reassignment, disability, sexual orientation, age, religion or belief, pregnancy and maternity, socio-economic background and any other distinction.

We have a Diversity Steering Group, which is chaired by our Director of Workforce and Organisational Development to ensure that the strategy implementation is monitored and evaluated. We have also set up a number of staff network groups to take our work forward.

We have continued to run diversity workshops for our managers to ensure that they understand the concepts of unconscious bias, their responsibilities under the Equality Act 2010 and how to ensure that all staff are treated with dignity and respect.

We are part of the NHS Employers Diversity Partners Programme and have worked with trusts across the country in order share learning and best practice. We have also welcomed the national lead for the Workforce Race Equality Scheme, Yvonne Coghill, into the Trust to support us with our agenda.

We also met our responsibilities under the Gender Pay Gap reporting requirements and have published our results, providing an explanation for our pay gap. Our average gender pay gap as a mean average was 6.53% and can be explained due to our workforce being 52.5% male who have considerable length of service with the Trust.

We aim to make the Trust a place where all who work and access our services are treated with dignity, respect and fairness. The Trust is a place free from unlawful discrimination, bullying, harassment and victimisation and where the diversity of our staff, patients, visitors and service-users is recognised as a key driver of our success and is openly valued and celebrated.

Our Workforce Profile

	2015 (31 March 2015)	2016 (31 March 2016)	2017 (31 March 2017)	2018 (31 March 2018)
Paramedics (including student paramedics)	1,437	1,592	1,685	1,668
Technicians	307	402	587	664
Emergency Care Assistants	445	557	610	599
Other frontline staff (including Assistant Practitioners, A&E Support Assistants, Intermediate Care Assistants)	391	224	193	151
Patient Transport Service (Band 2, Band 3 and apprentices)	713	688	832	618
Emergency Operations Centre (EOC)	362	360	374	442
NHS 111	401	380	465	524
Administration and Clerical staff	629	657	659	722
Managerial (including Associate Directors)	136	150	167	213
Other (Chief Executive, Directors and Non-Executive Directors)	15	16	17	17

Staff Profile - Gender

	2015 (31 March 2015)	2016 (31 March 2016)	2017 (31 March 2017)	2018 (31 March 2018)
Male	2,553 52.79%	2,638 52.49%	2,946 52.71%	2993 52.17%
Female	2,283 47.21%	2,388 47.51%	2,643 47.29%	2744 47.83%

Workforce Levels

Staff category	Establishment 31 March 2016		Establishment 31 March 2017		Establishment 31 March 2018	
	WTE	Headcount	WTE	Headcount	WTE	Headcount
A&E Operations	2,188	2,630	2,333	2,933	2,375	3,021
PTS	667	788	606	927	547	880
EOC/NHS 111	623	795	689	898	714	934
Support staff	534	600	543	613	554	657

Management	153	160	165	173	217	230
Apprentices	52	53	45	45	13	15
Total	**4,217**	**5,026**	**4,381**	**5,589**	**4,422**	**5,737**

Our Senior Leadership Team
2017-18 saw some changes to our senior management team and these changes will support the challenges the Trust faces in the coming year.

The Trust appointed Steve Page to the role of Deputy Chief Executive and these duties will be in addition to his role as Executive Director of Quality, Governance and Performance Assurance.

The Trust welcomed Christine Brereton to the role of Director of Workforce and Organisational Development. Christine joined the Board of Directors and Executive Team in November 2017 and is already beginning to make significant changes to support the Trust's workforce.

Our Board of Directors saw the appointment of Richard Keighley, Non-Executive Director, and the departure of Barrie Senior and Pat Drake, both Non-Executive Directors.
In our A&E Management Team, the Deputy Director of Operations retired in August 2017 and Stephen Segasby was appointed as his replacement. A General Manager for A&E Operations was also recruited.

2017 also saw the retirement of Dr Philip Foster, Director of Planned and Urgent Care, and this led to a review of the portfolio and the appointment of Leaf Mobbs to the Director of Urgent Care and Integration. The new name for the directorate demonstrates the changing role of planned care in our Trust. A Clinical Lead (GP) and General Manager for this directorate were also appointed in March 2018.

Leadership Development
The Management Essentials Programme continues to support newly recruited and promoted managers and leaders across the Trust. This programme is supported by an extended range of online resources available through the virtual learning site covering aspects of leadership, management and wellbeing.

For existing leaders we continue to build on capability around people management activities to embed an employee-centred approach in line with the refreshed Trust values. New additions this year have included recruitment and interview techniques workshops. These workshops promote employee wellbeing alongside the fair and consistent application of Trust policies.

The Trust is in the process of refreshing its core leadership offering and, as part of that, will be launching a programme for all formal leaders/managers entitled *Leadership In Action* from May 2018. The aim of the programme is to ensure it is clear to our leaders, what is expected of them, and to support leaders in developing their leadership skills, engage and motivate staff and role-model our values and behaviours.

Learning Technologies

We continue to grow and develop our online learning management system (YAS 247) to support staff learning across the Trust. This year has seen further integration of mandatory training, improving staff experience by replacing paper-based products with online solutions which are accessible on multiple platforms including mobile phones and tablets.

Our library of on-demand video content continues to grow with topics supporting clinical standard operating procedures. Application of learning technologies has been integral to enhancing clinical refresher training and increasing learner engagement. The Learning Technologies Team has maintained its commitment to recording, editing and hosting video footage for people unable to attend learning events. This has included the College of Paramedics best practice day, the Trust's leadership conference and the Chief Executive's monthly *Teambrief* sessions.

Apprenticeships

With the introduction of the Apprenticeship Levy, the Trust has placed further emphasis on apprenticeship programmes and how they can be utilised across all areas of the organisation to ensure we grow our own talent alongside new starter programmes. In January 2018 the Trust achieved approval as a training provider from the Education and Skills Funding Agency to enable the delivery of some of the apprenticeship standards to our workforce.

The deployment of apprenticeship training programmes across the Trust continues to evolve with a mixture of new starters and existing staff being signed up to start their programmes during 2017-18. This year the Trust introduced traineeships to our new starter programmes to equip our future apprentices with key skills, behaviours and competencies. The overall engagement with apprenticeships remains strong as we prepare for the new Apprenticeship Levy with 125 starters in 2017-18 compared to 84 in 2016-17.

We continued with our established schemes across all of our business areas including PTS, Estates, HR and Procurement. New schemes are being reviewed and will be introduced during 2018-19.

Through attending various career events and engaging with schools and colleges we have been actively promoting our apprenticeship scheme to reach all sections of our community, ensuring our apprentices reflect the population we serve.

Staff Engagement

Long Service and Retirement Awards

On Tuesday 12 September 2017 we honoured dedicated staff members who have served Yorkshire Ambulance Service for 20 years and beyond at the Long Service and Retirement Awards, many of whom attended on the day. In total, 259 members of staff clocked up around 6,000 years between them.

The event took place at Pavilions of Harrogate, led by Chief Executive Rod Barnes, Chairman Kathryn Lavery, Sector Commander Mark Inman and special guest Lord-

Lieutenant Mr Barry Dodd, Her Majesty's representative in North Yorkshire, to present YAS staff with their certificates and awards.

On the day, we were pleased to honour our exceptional staff who have served in the NHS for 20, 30 and 40 years. the Lord-Lieutenant presented staff with a certificate and an award for their long service. Additionally, the Queen's Long Service and Good Conduct Medal was awarded to frontline emergency staff for 20 years' exemplary service.

We honoured 82 members of staff for serving in the NHS for 20 years, 53 for 30 years' NHS service and five for serving an incredible 40 years with the NHS. We also awarded 22 Queen's Medals and recognised 97 retirees for their valuable service within the Trust and to the people of Yorkshire for many years.

In addition, we presented two posthumous awards to families who have lost their loved ones in service. Holly Smith and Marilyn Marshall sadly passed away in 2016 and we were honoured that members of their families could attend the ceremony to receive awards on their behalf.

WE CARE Awards

The sixth annual *WE CARE* Awards ceremony was held in York in November 2017 when staff and teams were honoured for their dedication, commitment and for going the extra mile for patients and colleagues.

At the special awards dinner congratulations went to over 130 members of staff who were nominated. The winners and those who were highly commended in each category were also announced.

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

He YAS staff across the Trust: "It's a real privilege to lead this organisation whose workforce makes a real difference to the lives of many people across our region every single day."

For 2018 this popular staff recognition initiative will be refreshed to reflect the newly introduced vision, values and behavioural framework.

YAS *Teambrief*

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

Freedom to Speak Up Guardian

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

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

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

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

Staff Surveys

The Trust operated the Staff Friends and Family Test each quarter during 2017-18 and took part in the national NHS Staff Survey 2017.

In the Staff Survey the Trust achieved a final response rate of **34.5%** (compared with 37% in 2016). The Trust opted for a full census and a total of 4,651 staff members were invited to participate. As a result of the responses, we have an action plan in place that aims to make improvements to our staff experience in order for the Trust to become an employer of choice.

We will continue to engage and involve our staff through our trade union partners and directly. It is essential that we meet and involve our staff in order that they are listened to and that they feel that they have a say in how our Trust operates and how they work within it. We will particularly involve our staff when implementing the new values and behavioural framework and our Diversity and Inclusion Strategy.

Recruitment, Resourcing and Retention
Recruitment into frontline roles has continued to be the main focus for the Trust as the demand on our services continues to increase.

The Trust has increased support in its call centres (EOC and NHS 111) in order to meet the significant increases in demand and to ensure that we can answer our patients' calls as quickly as possible. We have also invested and recruited into vacancies in our leadership and administrative support to ensure that our clinical staff can focus on patient care.

We currently hold monthly recruitment and selection days for Emergency Care Assistants and our Emergency Operations Centre (EOC) staff and these events have been popular and well attended.

The Trust is aware of its safeguarding responsibilities and ensures that it meets the NHS Employment Checking Standards for all our appointments. We are also committed to ensuring that we are compliant with the Fit and Proper Persons testing process and are rigorous in our execution of this duty.

We have reviewed our recruitment pathways to ensure that our processes are as efficient as possible and will continue this work in the coming months. Recruitment is a clear work-stream in our *Living our Values* programme in order to ensure that we recruit staff with the right values and behaviours and that they are clear on our values from day one.

Recruitment Activity

Staff Category	Number of Vacancies Advertised	Number of Applications
A&E Frontline	57	2,708
Apprentice*	3	4
EOC/NHS 111	51	2,410
Management	79	978
Patient Transport Service	59	1,740
Support	177	3,082
Grand Total	**426**	**10,922**

***** Please note the facilitation of Apprentice recruitment campaigns has been managed within the Learning and Development Team.

Attrition
During 2017-18 there were 812 people who left the Trust, including 105 who retired, 416 who resigned, 118 whose fixed-term contracts ended, 62 staff who were dismissed, 12 redundancies and sadly two staff who died in service.

Partnership Working
We work in partnership with UNISON, GMB, Unite the Union and the Royal College of Nursing as our recognised Trade Unions and our relationship continues to develop with our local and regional representatives. We are all committed to building strong employee relations and our transformation programmes across A&E, NHS 111 and the Patient Transport Service have involved our local representatives at their commencement.

We work with our trade unions to develop and review policies and processes to ensure they are fair, consistent and in line with best practice.

This year we have worked together to implement the regrading of our paramedics, which was as the result of a national job evaluation exercise and are currently working together to improve our Dignity at Work (Bullying & Harassment) Policy which supports the Trust's new Diversity and Inclusion Strategy.

We have also worked closely with the National Ambulance Service Partnership Forum on national projects including paramedic regrading and in the coming months we will be working together on healthy workplace projects.

Health and Wellbeing
The Trust's Health and Wellbeing Plan for 2017-18 focused on 'Healthy Minds, Healthy Bodies, Healthy Lifestyles' and we undertook a number of initiatives to ensure that our staff remain well at work or are supported if they are required to be absent.

To support Healthy Minds, we are working closely with the Trust's Occupational Health provider to ensure staff receive timely access to counselling and support services. We also commenced Mental Health First Aid Training for all our Clinical Supervisors and over sixty managers across the Trust have recently accessed mental health awareness training to enable them to support and manage the needs of their teams more effectively.

A significant of training for our managers and staff is planned to ensure that our staff are supported to remain well at work. We also supported the national *Time to Change* campaign for staff which promotes breaking down barriers to talking about mental health. Again, we will continue the promotion of this campaign during 2018-19.
For our Healthy Bodies work-stream, we undertook back care workshops with our call centre staff. This initiative provided a registered physiotherapist to undertake walk-arounds to give advice on back care, good posture, and management of MSK issues. These workshops were well received and we will continue this programme during 2018-19.

The 2017-18 flu vaccination campaign had a fantastic uptake with over 65% of staff having the vaccination. This success was due to a number of key elements and the Trust is now working on a number of new strategies to ensure that this success is built on with a target of 75% to be achieved in 2018-19.

For Healthy Lifestyles, the Trust promoted the national 'One You' campaign and promoted the benefits of healthy eating. We are working with our trade unions and Emergency Operations Centre to ensure that our staff receive their well-earned rest breaks and are able to finish work on time so that they can spend time at home with their families.

Absence Management
Our threshold for sickness absence is 5% and unfortunately our absence percentage has been above this level throughout the year. We lost an average of 7,828 calendar days each month due to sickness absence, which although is slightly lower than 2016-17 (7,963 calendar days) it is unsustainable.

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

Calendar Days Lost

	April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total (2017-18)	6,907	6,781	6,886	7,658	7,687	7,587	7,548	7,437	8,584	9,634	8,570	8,666
Total (2016-17)	7,264	7,229	7,026	7,799	7,917	7,706	8,063	7,875	9,084	9,121	7,979	8,498

Sickness Absence Percentage

	April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trust Total (2017-18)	5.33%	5.08%	5.35%	5.76%	5.78%	5.83%	5.58%	5.65%	6.30%	7.06%	6.96%	6.35%
Trust Total (2016-17)	5.12%	4.86%	4.91%	5.30%	5.43%	5.40%	5.41%	5.37%	5.96%	5.97%	5.84%	5.64%

Pay and Reward

We pay the majority of our staff in accordance with the national pay framework, Agenda for Change. We have fully implemented and continue to operate the job evaluation system that is provided.

All other staff are paid in accordance with the national minimum wage, the apprenticeship rates or NHS Improvement's Very Senior Manager pay. The Trust does not employ any staff on the national Doctors and Dentist's pay framework including the Terms and Conditions of Service for Consultants.

Permanent and Other Staff

Employee benefits are split between permanent and other staff as set out in the table below.

Staff costs

	Permanent £000	Other £000	2017/18 Total £000	2016/17 Total £000
Salaries and wages	140,203	-	**140,203**	134,584
Social security costs	13,714	-	**13,714**	13,247
Apprenticeship levy	683	-	**683**	-
Employer's contributions to NHS pensions	17,111	-	**17,111**	16,244
Termination benefits	235	-	**235**	349
Temporary staff		3,187	**3,187**	6,692
Total staff costs	**171,946**	**3,187**	**175,133**	**171,116**

Average number of employees (WTE basis)

	Permanent Number	Other Number	2017/18 Total Number	2016/17 Total Number
Medical and dental	3	-	**3**	3
Ambulance staff	3,706	65	**3,771**	3,753
Administration and estates	556	38	**594**	634
Nursing, midwifery and health visiting staff	77	19	**96**	83
Scientific, therapeutic and technical staff	2	1	**3**	3
Total average numbers	**4,344**	**123**	**4,467**	**4,476**

Exit Packages

Exit packages costing £235,028 for 14 staff were provided during the year. This compares to £348,665 for 11 staff in 2016-17.

Exit Packages agreed in 2016-17

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

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

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

Exit Packages agreed in 2017-18

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	*Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	5	£23,342	0	£0	5	£23,342
£10,001 - £25,000	4	£55,670	1	£22,757	5	£78,427
£25,001 - £50,000	3	£107,169	1	£26,090	4	£133,259
£50,001 - £100,000	0	£0	0	£0	0	£0

£100,001 - £150,000	0	£0	0	£0	0	£0
£150,001 - £200,000	0	£0	0	£0	0	£0
>£200,000	0	£0	0	£0	0	£0
Total	**12**	**£186,181**	**2**	**£48,847**	**14**	**£235,028**

Note: We closed our NHS 111 Call Centre in York and made significant changes to our Estates Directorate; both these organisational changes meant that we were required to make 12 staff redundant. The Trust's Mutually Agreed Resignation Scheme (MARS) was closed in May 2017 and hence the number of MARS applications reduced significantly.

Exit Packages – other departures analysis

Other exit packages - disclosures (Exclude Compulsory Redundancies)	2017-18 Number of exit package agreements	2017-18 Total value of agreements	2016-17 Number of exit package agreements	2016-17 Total value of agreements
	Number	**£000**	**Number**	**£000**
Voluntary redundancies including early retirement contractual costs	0	0	3	54
Mutually agreed resignation scheme (MARS) contractual costs	2	49	7	152
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non contractual payments requiring HMT approval *	0	0	0	0
Total	**2**	**49**	**10**	**206**
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

Financial Review

Income and Expenditure

During 2017-18 the organisation had a planned surplus of £3.4m (including £1.5m Sustainability and Transformation Funds (STF)). The final position was a total surplus excluding STF of £4m (£2.1m above plan). This means the Trust has earned an additional £5.3m STF of which £3.8m was bonus and incentive STF. The Trust surplus including STF was £9.8m after technical adjustments; the total adjusted financial performance was a surplus of £9.3m. The key reasons for this are set out in the notes below.

We are planning to deliver a surplus of £4.188m in 2018-19 including £2.1m STF.

Income

The Trust received income of £269.5m in 2017-18. This is £14.1m higher than income received in 2016-17. The increase reflects increased activity and investment in our A&E services amounting to £9.2m and PTS contracts of £1.3m. STF income has increased by £4.2m since 2016-17. The balance reflects other movements in contracts and activity.

Service	£m	%
A&E	184.9	69%
NHS 111	34.9	13%
PTS	30.3	11%
STF	5.3	2%
Other	10.7	4%
HART	3.4	1%
Total Income	**269.5**	**100%**

The financial plan for 2018-19 assumes a planned level of income excluding STF of £268.1m (£270.2m including STF of £2.1m).

Expenditure

Combined revenue expenditure in 2017-18 was £259.8m; this was £6.7m higher than 2016-17. The breakdown of total expenditure can be seen in the table below:

Expenditure	£m	%
Pay Costs	175	67%
Non-pay costs	73.3	28%
Depreciation & Amortisation	9.4	4%
PDC Dividend	2.1	1%
Total Spend	**259.8**	**100%**

During 2017-18 pay costs increased by £3.9m; this reflects increases associated with the national pay award, incremental progression increases of £2.5m and an additional cost of £1.4m associated with the re-banding of paramedics.

Non-pay expenditure has increased by £3.1m over the 2016-17 level. The Trust invested additional funds in medical equipment, estates and increased provisions against legal costs.

Quality and Efficiency Savings/Cost Improvement Plans

The Trust had a planned cost improvement programme of £12.4m for 2017-18 (4.6%). The actual performance of all schemes totalled £13.6m (110% of planned savings). Over 80% these cost improvements were of a recurrent nature.

The planned level of cost improvement programme for 2018-19 is £9m.

Capital Expenditure

After changes during the year following repayment of a loan from the Department of Health, the Trust's Capital Resource Limit (CRL) was set at £8.7m for 2017-18. We spent £7.6m on capital expenditure and received £0.2m in respect of assets sold during the year. Therefore, the charge against CRL was £7.4m and we achieved the CRL target with a £1.3m underspend.

The largest area of expenditure was £5.2m on fleet and medical equipment, this included £2.3m on defibrillators, £1.9m on A&E vehicles and £0.8m on stretchers.

Remaining capital expenditure related to station refurbishment and upgrades of £0.6m, support services' buildings refurbishment and upgrades of £0.4m and information technology of £1.2m, which includes the purchase of the new Fleet Management System. There was also £0.2m spent on the design team work associated with Hub and Spoke developments.

Cash/External Financing Limit (EFL)

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

This year the planned cash inflow before financing was £4.4m. The actual cash inflow before financing was £12.8m, an under-shoot of £8.3m. This reflects a £2m overachievement against plan, STF incentive and bonus payments amounting to £2.1m and £1.7m, and additional funding of £0.9m from the distribution of reserves held by clinical commissioning groups, along with movements on working capital.

Capital Cost Absorption Duty

The Capital Cost Absorption Duty measures the return the Department of Health makes on its investment in the Trust. It is set at 3.5% of the average carrying amount of all assets less liabilities, less the average daily cash balance in the Government Banking service or National Loans Fund accounts. The average relevant net assets figure for the period was £58.5m. The public dividend capital reflected in the accounts was £2.049m which equates to 3.5%, thereby achieving the target.

Better Payment Practice Code (BPPC)

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

During 2017-18, the Trust paid 24,404 invoices of which 20,741 were paid within 30 days, giving an overall BPPC position of 85% against the target of 95%. We paid 527 NHS invoices in the year, of which 415 (78.7%) were paid within 30 days. We paid 23,877 non-NHS invoices, of which 20,326 (85.1%) were paid within 30 days.

In total, the value of payments made during 2017-18 was £106.96m, of which £99.39m (92.9%) was paid within 30 days.

The comparative values for 2016-17 were: 31,420 invoices, of which 27,588 were paid within 30 days giving an overall BPPC position of 87.8% against the target of 95%. We paid 551 NHS invoices in the year, of which 447 (81%) were paid within 30 days. We paid 30,869 non-NHS invoices of which 27,141 (87.9%) were paid within 30 days.

Pensions Liabilities

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

At the end of the year, we have accrued £2.224m in our balance sheet for March contributions. Details of the accounting policy on pension costs can be found in the full accounts for the year at Note 9. Pension entitlements in respect of Senior Managers are contained within the remuneration report that follows.

External Auditor's Remuneration

Ernst & Young provide external audit services to the Trust. For 2017-18 these costs were £68k.

Sickness Absence Data

Each year the Department of Health publishes sickness absence figures for the Trust. The number of days lost to sickness absence between January and December 2017 was 55,452. This equates to an average of 12.8 sick days per full-time equivalent (FTE) employee. The comparable values for the same period during the previous financial year were 52,239 days, equating to an average of 12.3 days per employee.

Cost Allocation and Charges for Information

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

Exit Packages and Severance Payments

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

Off-payroll Engagements

For all off-payroll engagements as of 31 March 2018, for more than £220 per day and that last longer than six months:

	Number
Total Number	**2**
Of which:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	0
for between two and three years at the time of reporting	0
for between three and four years at the time of reporting	1
for four or more years at the time of reporting	0

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	0
Number of individuals that have been "board members, and/or senior officers with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements	0

For all new off-payroll engagements between 1 April 2017 and 31 March 2018, for more than £220 per day and that last longer than six months:

Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	**1**
Number of new engagements which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations	**1**
Number for whom assurance has been requested	**1**
Of which:	
assurance has been received	0

Consultancy

Consultancy spend of £546k (£977k 2016-17) related to work on a range of key projects, including Estates (£144k), Organisational Development (£119k), Accident and Emergency (£87k) and Standards and Compliance (£66k), alongside a number of other projects across the Trust.

Signed: 

Rod Barnes, Chief Executive 24 May 2018

Annual Governance Statement and Head of Internal Audit Opinion

(extract from Internal Audit Annual Report)

YAS Annual Governance Statement 2017/2018

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS 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 NHS 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 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 Yorkshire Ambulance Service NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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

The Board sets the strategic aims for the organisation and ensures that resources are in place to meet its objectives. It receives reports at each meeting of the Board held in public on the principal risks and associated actions as detailed in the Trust's Board Assurance Framework, through a combination of risk management reports, appropriate scrutiny and reports from the Board sub-committees.

The Board meets quarterly in public, with additional meetings in private and Board Development Meetings scheduled on a two monthly basis. The Trust Board currently consists of:

- Chairman *
- 5 Non-Executive Directors (NEDs) *
- 2 Associate Non-Executive Directors
- Chief Executive Officer *
- Executive Director of Finance *
- Executive Director of Operations *
- Executive Medical Director *
- Executive Director of Quality, Governance and Performance Assurance/ Deputy Chief Executive *

- Director of Workforce and Organisational Development
- Director of Urgent Care and Integration

(* denotes voting members)

In addition, the Board functions are co-ordinated and supported by the Trust Secretary. The Board is primarily responsible for:

- Formulating strategy – vision, values, strategic plans and decisions
- Ensuring accountability – pursuing excellent performance and seeking assurance.
- Shaping culture – patient focus, promoting and embedding values
- Engagement with internal and external stakeholders to support delivery of Trust aims and objectives.
- Supporting and ensuring the financial balance of the organisation.

During the year there have been changes to Board personnel, as follows:-

- The Director of Planned and Urgent Care retired and following this the portfolio was reviewed and a new Director of Urgent Care and Integration was appointed in November 2017.
- A new substantive Director of Workforce and Organisational Development began with the Trust in November 2017.
- A new Chair of Audit Committee is joining the Trust from April 2018.

Over the year, the Board, with its Committees, continued to assess its own effectiveness whilst leading through a period of change, and to develop its ability to focus on strategic issues whilst assuring itself of the performance of the whole organisation. It has achieved this by the following:

- A co-ordinated work plan across the Board and its Committees, to ensure a focus on key decisions and governance dates during the year.

- Regular Board Strategic Development Sessions, to cover key strategic and development issues which have included:
    a. The Trust's five-year Corporate Strategy Development.
    b. Self-Assessment versus the Well Led framework and 8 Key Lines of Enquiries.
    c. Development of suitable Transformation governance arrangements in the context of the emerging national integrated Urgent Care agenda.
    d. Approaches to collaborative working across the Northern Ambulance sector through the Northern Ambulance Alliance and national Director level work streams.
    e. Financial Priorities, Performance and Planning aligned to the revised planning guidance.
    f. Quality governance including consideration of core Health and Safety requirements across the trust and the new Care Quality Commission Inspection regime and compliance expectations.
    g. Board governance and committee arrangements.
    h. Risk management including the Board Assurance Framework and risk appetite.

i. The Board role in Health and Safety.
j. The Board role in delivery of the Diversity and Inclusion agenda, including having two sessions with the national lead for Race Equality to support the development of a plan including relevant board membership mix is representative the population we serve.

The Trust arrangements for quality governance are fully aligned to ensure compliance with the CQC Fundamental Standards and Well-Led framework. During the year representatives of NHSI have met regularly with Executive Directors and with the Trust Chairman, to gain assurance on the rigour of Trust governance processes.

The Trust Board has been underpinned throughout 2017/18 by five key committees/management groups:

- The Audit Committee
- The Finance and Investment Committee
- The Quality Committee
- The Trust Executive Group; and
- The Trust Management Group.

In addition, the Remuneration and Terms of Service Committee advises the Trust Board about appropriate remuneration, terms of service, contractual arrangements and performance evaluation for the Chief Executive and other Executive Directors. The Charitable Funds Committee also supports the Board in discharging its responsibilities as trustees of the Trust charitable funds.

The above mechanisms allow the Board to assure itself in relation to the Trusts provider licence compliance requirements.

The Trust Executive Group (TEG) meets weekly and has four key functions: Strategy and Planning, Systems of Management Control, Assurance and Performance and Risk Management. This specifically includes the following responsibilities:-

- Develop Strategy, Business and Operating Plans for approval of the Board;
- Oversee the day-to-day management of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities, both clinical and non-clinical, which also supports the achievement of the Trust's objectives and compliance with relevant regulatory, legal and code of conduct requirements;
- Review key areas of governance and risk highlighted through the Performance Management Framework;
- Develop and embed the policies, processes and systems required to support Trust wide delivery of the strategy, ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements;
- Deliver all risk and control related disclosure statements, in particular the Annual Governance Statement and declarations of compliance with the Essential Standards of Quality and Safety, prior to endorsement by the Board;
- Manage all significant risks, incidents and events, ensuring effective action to mitigate future risk.

The Chief Executive Officer, as Accountable Officer, presents a progress report from the TEG to each meeting of the Board.

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

The Executive Director of Quality, Governance and Performance Assurance has lead responsibility for managing the development and implementation of risk management (excluding financial risk management) and integrated governance. The Director routinely provides the Trust Board, the Quality Committee, Audit Committee and other management groups with expert advice and reports on risk management and assurance. The Director ensures that the Board has access to regular and appropriate risk management information, advice, support and training where required.

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

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

The Trust Management Group (TMG) reports to Board via TEG, and consists of the Executive Directors and Associate Directors and is chaired by the Chief Executive. The TMG provides TEG with assurances on governance and compliance on areas of delegated responsibility, including:- monitoring and review of performance in relation to operational, quality, workforce and financial objectives, identification and management of key risks, including review of the Board Assurance Framework and Corporate Risk Register, action to address key risks to delivery and on operational issues and problems, overseeing delivery of the Trust service transformation programme and cost improvement programme, Internal Audit Plan progress and annual planning process and contributing to the development of strategy and policy including the Operational Plan development and Business Planning Development.

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

Risks are identified proactively by the Board and senior management team as part of the five-year and annual business planning cycles. As part of this process the Board assesses its overall risk profile, taking into account the key business risks, Trust capacity and capability to address these, and the Board's appetite for risk including the target residual risk. The Board agrees an annual risk appetite statement. This information informs the Board Assurance Framework and its use during the year by the Board and its Committees. The Board Assurance Framework goes through an annual cycle of strategic review lead at Board Level. The focus of board discussions are in relation to strategic risks to YAS in line with our Strategy and Business Plan.

Additionally we encourage and expect that risks are identified on a daily basis throughout the Trust by any employee/volunteer. During 2017/18 the Trust has maintained robust processes to support staff in raising concerns about quality and safety in line with the national Freedom to Speak Up recommendations. The identified risks vary significantly in scope, content, likelihood and impact and hence the measures for addressing them have also varied. Having identified a risk, a thorough risk assessment is carried out following the guidance for on-going risk assessment, described in the Trust Risk Escalation and Reporting Procedure.

When risks have been identified, each one is analysed in order to assess what the likely impact would be, the likelihood of this impact occurring and how often it is likely to re-occur. Impact and Likelihood are rated on a 5x5 scale, to give an overall risk rating of 0-25. When evaluating risks; consideration is given to any existing controls for that risk and importantly the adequacy and effectiveness of those controls. All risks and associated risk treatment plans are recorded and regularly updated in the Datix risk management system. This is used as the basis for monthly review of existing and emerging risks involving all departments, via the Risk and Assurance Group for moderation and discussion in relation to mitigations in place. The Chair of RAG reports into the Trust Management Group, where a monthly report on the corporate level risks are provided and discussed.

Risks that cannot be managed through TMG are passed up through the line of management, to the Trust Executive Group and ultimately to the Board, which is notified of all risks with a rating of 12 or above within the organisation that cannot be adequately eliminated or controlled. The Board has ultimate responsibility for deciding how the Trust then manages those risks.

Staff are specifically supported and equipped to manage risk appropriately through a variety of mechanisms, including the following:-

- Induction process includes a session on risk management and learning.
- The Risk and Assurance Group consists of operational and service leads across the trusts business to ensure corporate oversight and consistent understanding of risks.
- Specific thematic groups which staff attend consider and mitigate risks across the business such as the Information Governance Working Group, Incident Review Group, Clinical Governance Group, and Integrated Business Planning Group.
- Each directorate has a nominated risk lead that the risk team support in terms of guidance in identifying and escalating risks in line with policy. The risk team meet with these leads on a regular basis.

The risk and control framework

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

Quality Risk Governance

Quality is a central element of all Board meetings. The Integrated Performance Report, focuses on key quality indicators, and this is supplemented by more detailed reports containing both qualitative and quantitative information on specific aspects of clinical quality. Patient stories are used in each meeting of the Board, to ensure that the focus on quality of patient care remains at the heart of all Board activity.

The Quality Committee was introduced as a committee of the Board in March 2012 following a comprehensive review of corporate governance arrangements. The Quality Committee consists of three Non-Executive Directors, the Executive Director of Quality, Governance and Performance Assurance, Executive Medical Director, Executive Director of Workforce and OD and senior managers. The Committee undertakes objective scrutiny of the Trust's clinical governance and quality plans, compliance with external quality regulations and standards and key functions associated with this, including processes to ensure effective learning from adverse events and infection prevention and control. A key element of this work is scrutiny of the quality impact assessment of cost improvement plans and other service developments. The Committee also supports the Board in scrutinising and gaining assurance on risk management, workforce governance, health and safety and information governance issues. It also provides scrutiny in relation to the actions required as a result of external investigations and enquiries.

A Clinical Quality Strategy which covers a three-year period from April 2015 -18 describes the priorities for clinical quality and is underpinned by an annual implementation plan covering the key work streams. A full review of the Clinical Quality Strategy has taken place in 2017/18 and a new Quality Improvement Strategy has been discussed by the Board and will be approved in May 2018 to cover a three year period, with a focus on active involvement and empowerment of staff in all areas to support continuous quality improvement.

The Board and Quality Committee regularly review issues, learning and action arising from Serious Incidents, other incidents and near misses, complaints and concerns, serious case reviews, claims and coroners' inquests. During the year no nationally defined 'Never Events' have occurred as a result of Trust care or services.

General Risk Governance.

The Trust recognises that in order to be most effective, risk management must become part of the organisation's culture. The Trust strives to embed risk management into the organisation's philosophy, practices and business processes rather than be viewed or practiced as a separate activity. Our aim is for everyone in the Trust to become proactively involved in the management of risk, and as such we continue our commitment to working in line with the Risk Maturity Matrix, upon which our Internal Audit of Risk Management last year was based. A plan is now being delivered that further takes the Trust up that maturity matrix and supports the further embedding of systematic risk management practices across the trust.

The Risk Management and Assurance Strategy and supporting Risk Escalation and Reporting Procedure defines the process which specifies the way risk (or change in risk) is identified, evaluated and controlled, and is consistent with available best practice guidance. This Risk Management and Assurance Strategy and associated procedural documents are actively promoted by managers to ensure that risk management is embedded through all sections of the Trust.

The Board Assurance Framework and Corporate Risk Register enable the Board to examine how it is managing the risks that are threatening the achievement of strategic objectives. Both of these documents are closely aligned and subject to comprehensive Executive and Non-Executive review on a quarterly basis.

Close liaison between the risk and safety managers and business planning managers has ensured that business planning informs and is informed by risk management. Key business risks and mitigations are captured in the Integrated Business Plan and Operating Plan.

A quality impact assessment process ensures that all decisions on efficiency savings and expenditure on new developments are objective, risk based and balanced, taking account of costs and savings, impact on quality and ease of implementation. The quality impact assessments and associated early warning indicators are subject to review in each meeting of the Quality Committee.

The organisation's major risks are identified at a corporate level. The Trust identifies risk to its annual business plan and five year Integrated Business Plan, and aims to prioritise and manage the principal risks that may impact on the achievement of the Trust's strategic objectives and implementation plans.

The most significant risks to the strategic objectives identified in 2017/18 were:

- Inability to deliver performance targets and clinical quality standards.
- Lack of capacity and capability to deliver and manage change including delivery of cost improvement programmes.
- Inability to deliver the plan for integrated patient care services owing to multiple service tenders.
- Availability of clinical workforce impacting ability to deliver the operational business plan.
- Impact on delivery of strategic objectives and performance delivery due to external system pressure and changes in the wider health economy.
- Potential failure to deliver on financial plans and efficiency programmes and the impact on the wider economy.

Other risks recorded in the Board Assurance Framework 2017/18 were:

- Ineffective strategies for staff engagement.
- Ineffective joint working between corporate teams and operational service lines.

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

Monthly iterations of the Board Assurance Framework are supported by separate risk movement and assurance movement reports. These reports provide detail on the actions taken to mitigate the strategic risks and any reports received that could provide the Trust Board with assurance. The Board and its committees also receive reports on the corporate risk register, to enable a deeper review of emerging risks and of the flow of risk information between operational departments and the Board. We report on the quarterly position of management of the risks in relation to the BAF through TMG, TEG and Board.

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

- In year, the ongoing challenge relating to delivery of Ambulance response times remained significant especially in the context of changing Ambulance Response Programme standards. The challenges remain to response times and this created a potentially increased risk to safety and quality of patient care, which required close monitoring and mitigation. The Board and Trust Executive Group have considered the risk in detail and have worked extensively with commissioners during the year to mitigate the risk. The additional workforce recruited and trained during the delivery of the A&E transformation programme has significantly supported the Trust in absorbing a considerable increase in demand on service. However during 2017/18 the Trust participated in the development of new national ambulance response standards through the Ambulance Response Programme, and these standards have now been formally introduced. The new ARP standards are designed to enable Trusts to target resources more effectively in response to clinical need, but it is recognised that full delivery will require significant investment and service transformation. The Trust is working with commissioners and through the internal Service Transformation Programme, on a number of medium term plans to help mitigate this risk and improve response times. The achievement of these standards will continue to pose a challenge to the Trust in the coming year. The level of demand and effectiveness of the wider health and social care system will also continue to be a significant contributing factor. Delays in hospital Emergency Department turnaround and changes to ambulance service requirements arising from local service reconfigurations remain significant factors requiring mitigating action.

The Trust is continuing to work proactively with commissioners and system partners including acute hospital trusts through a variety of forums, to mitigate these system risks.

- Recruitment and training of staff continues to be a risk, with a national shortage of trained paramedics creating a specific challenge to delivery of the Trust's five-year workforce plan.

During the year, revisions have been made to the workforce plan to increase recruitment and internal training provision and to embed our new clinical career framework and this will remain a key focus across the service lines, and in particular in relation to qualified staff, pending the planned increase in Paramedic and Nurse training nationally over the coming years.

- During the year the pressure on the NHS 111 service increased as demand for the service continued to rise above the levels funded through the contract. Pressures throughout the year impacted on achievement of the national response targets for NHS 111 calls, but internal mitigating action has ensured continued delivery of a safe and effective service to patients. The Clinical recruitment programme in NHS 111, led by an Executive level sponsor has supported the mitigation of risk in relation to availability of suitable clinicians however there is still improvement required in relation to the clinical advice standard. Emerging risks and opportunities in relation to NHS 111 link to meeting the standards set out in the Integrated Urgent Care national specification and the re-tendering of the service.

- Employee relations still present a key challenge for the Trust. The Executive team, with the support of Board, continue to focus on developing mechanisms and relationships to help support constructive working relationships with all of the key unions. This is complemented by a significant focus on wider employee engagement and more robust staff communication and engagement, including the co-development of updated Vision and Values and a Trusts wide Behavioural Framework that was launched in January 2018, an increased focus on staff well-being and the launch of the Quality Improvement initiative.

- Patient Transport Service has successfully won a number of tenders over the year for large areas of the geography including Vale of York and Scarborough, East Riding and the South of the patch. There remains a significant risk to this service areas continuity going into next year, with further bid activity expected in West Yorkshire.

- Within Workforce and OD there had the previous year been a high level of turnover amongst senior and management roles. This year saw the appointment of a substantive Director in November 2017 which has allowed some of the changes required to be solidified. The full senior management team is now in place and core areas of improvement are starting to be embedded with the introduction of a new Behavioural Framework, widely consulted upon together with the trusts updated Vision and Values, and has progressed the development of a Leadership and OD Strategy that aligns to our 5 year strategy development. Additionally there is an updated Diversity and Inclusion Strategy and Plan which is sponsored at Board level. There has also been the introduction of a Strategic Workforce Group, chaired by the new Director, which is underpinned by newly introduced Governance structures. The aim of which is to oversee core OD changes that are required and to ensure a systematic and consistent approach.

In addition to monitoring by the Board and Audit Committee, progress against risk treatment plans have been routinely discussed in each meeting of the Quality Committee and Finance and Investment Committee.

All corporate risks subject to on-going risk management plans will be recorded on the 2018/19 iteration of the Board Assurance Framework and will continue to be managed through the Corporate Risk Register.

The Internal Audit programme for 2017/18 focused on areas of risk for the organisation. In the current year a total of 22 reports were produced with relevant assurance ratings, of which a small number were considered to provide a "reasonable" level of assurance, as opposed to substantial or good

A number of issues were highlighted during the year as a result of the Internal Audit programme in aspects of:-

- Data quality/KPIs due to a lack of documented procedures for the development of and reporting of KPIs in relation to specific workforce measures.

- Inspections for improvement, relating to the need to strengthen formal follow up on recommended action and the governance arrangements relating to those actions.

- End-of-Shift Overtime, the robustness of systems in relation to verification of accurate end of shift overtime claims has improved since previous audits but still requires further work to ensure a systematic approach across A&E.

These issues have been considered in the relevant management forum and mitigating action agreed to resolve any outstanding issues. The Audit Committee reviews management assurance on completion of related action plans. The Trust also has in place an annual counter fraud work programme, which is monitored via the Audit Committee.

Significant issues and risks going into 2018/19 informed by the recent annual board review of the BAF and the recent Well Led self-assessment conducted by the board include:-

- Delivery of the Ambulance Response Programme (ARP) standards by September 2018.
- The pace and scale of external reconfigurations across the patch, which is resulting in increased journey times and increased transfer activity across sites, thus taking resource out of a number of areas with resulting performance impacts and potential safety impacts to consider.
- Financial performance going into next year will continue to be a challenge in the context of national expectations, anticipated demand levels, increasingly high turnaround times across the patch and major service reconfigurations that are still ongoing.
- Leadership capacity and capability to deliver our 5 Year Strategy as we go through unprecedented change as a system and a Trust has been identified as an emerging risk through the annual BAF review by Board and the Well Led Self-assessment.

- Tendering activity relating to NHS 111, West Yorkshire Urgent Care and West Yorkshire PTS.
- On-going relationships with key Trade Unions remains an issue as highlighted through the Well Led self-assessment process.

Risk mitigation plans in relation to the key risks for 2018/19 are as follows:-

The risk relating to delivery of the ARP standards is being addressed through ongoing implementation and embedding of a multi-faceted transformation programme and continued implementation of the 5-year workforce plan. This is underpinned by rigorous diagnostic activity and will be supported by continued strategic engagement with commissioners and other stakeholders, and extensive staff engagement and communication. The Trust is in discussion with Commissioners in relation to the need for additional investment to help achieve the ARP standards in line with planning guidance expectations, a number of business case are being developed as a means of mitigation and to support future delivery.

In terms of impacts of service reconfigurations across Acute Trusts this is being managed at Executive level through Integrated Care Systems and STPs, liaison with key officers at acute trusts, and on a case by case basis, with the support of the Lead Commissioner and Regulators.

Employee relations continue to present a challenge during this period of intense change, and are also heavily influenced by the national context in the light of ongoing discussions around national pay settlement and unsocial hours. The Trust is taking forward major initiatives to embed the new Values and Behavioural Framework, to promote employee involvement through the Quality Improvement strategy, to support staff well-being, and to improve the scope and quality of communications including increased use of social media. Relations with trade unions will be maintained through the established formal mechanisms and through increased engagement in key service transformations and improvements.

The risk in relation to our financial performance is being addressed through the development of robust and sustainable financial plans. The current plan assumes stretching targets in terms of efficiencies in line with benchmarking. This allows the Trust to plan to perform against a control total which will allow the Trust to access Sustainability Funds, In addition it allows for some investment in frontline services in order to work towards the achievement of challenging national performance standards. The internal trust performance management of our financial position is led by our Executive Director of Finance, through Board, Finance and Investment Committee, Trust Executive Group, TMG and CIP Management Group. Potential quality impacts of all CIPs are reported through to Quality Committee. In terms of opportunities to collaborate across the sector, this work is being led by our Chief Executive and includes focussed collaboration through the Northern Ambulance Alliance Board. The Chief Executives of the 3 trusts are exploring opportunities for economies of scale and collective purchasing power to drive better value across a number of agreed work streams, in line with the proposals of the Lord Carter review. Wider opportunities for collaboration are also being explored through the Association of Ambulance Chief Executives, with Emergency Service partners, and through the local Service Transformation Partnerships.

In relation to leadership capacity and capability to deliver the Trusts 5 Year Corporate Strategy key mitigations include, the appointment of Price Waterhouse Cooper to conduct our Well Led external review, commencing in March 2018, the appointment of an external support package specific to Board and the Executive team in relation to collective and individual leadership, the launch of refreshed vision and values and Behavioural Framework, the launch of a Talent Management model for the Trust and the Leadership Development Programme.

Our approach relating to tenders across PTS and NHS 111 is to plan up front for all the elements that our experience tells us we will be required to submit as part of the tender process. Additionally work is underway, led by the Director of Urgent Care and Integration, to ensure that appropriate resources are put in place to support the bid teams in putting forward robust bids, including the financial planning and quality elements which will be critical to success.

Management of these risks will be monitored during 2018/19 through the Trust Executive Group, Finance and Investment Committee, Quality Committee, Audit Committee and Board. Additional monitoring and assurance will be provided through the Trust Service Transformation Programme, to oversee the delivery of key developments aligned to the Trust 5-year business plan.

The Trust is fully compliant with the registration requirements of the Care Quality Commission and the Trust maintains a robust internal overview of compliance to ensure that standards are maintained throughout the year.

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.

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

The trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Trust has also this year developed its Policy and approach in relation to the risks associated with Modern Slavery.

The Trust has in place a "Freedom to Speak up" Guardian to further support a culture of openness and transparency in the management and mitigation of risks across the trust.

Review of economy, efficiency and effectiveness of the use of resources

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

The Finance and Investment Committee (F&IC) was introduced from May 2011, following a review of Trust committees conducted in 2010/11. The F&IC is a formal committee of the Trust Board and is chaired by a Non-Executive Director. The Committee includes three Non-Executive Directors, the Executive Director of Finance, the Chief Executive, the Executive Director of Workforce and OD and senior managers. The Committee undertakes objective scrutiny of the Trust's financial plans, investment policy and major investment decisions, and as such plays a pivotal role in financial risk management. It reviews proposals for major business cases and reports on the commercial activities of the Trust, and also scrutinises the content and delivery of the Trust cost improvement programme.

There is also a robust process in relation to the identification of Cost Improvement Plans led by the Executive Director of Finance, with support from the Programme Management Office. This is an ongoing process which is refreshed on an annual basis and seeks to ensure that the Trust is operating more efficiently year on year and aims to allow for greater investment in areas of need in front line services.

Information Governance

Reference is made within the Risk Management and Assurance Strategy to the Information Governance Policy which describes, in detail, the arrangements within the Trust for managing and controlling risks to data security. The Senior Information Risk Officer role for the Trust is undertaken by the Executive Director of Quality, Governance and Performance Assurance, supported by the Trust's Executive Medical Director as the Caldicott Guardian.

Information Governance Compliance

The annual self-assessment against the Information Governance Toolkit was completed at the end of March. For 2017/18 we have declared an overall 'satisfactory' rating level 2 on all applicable Toolkit requirements.

Data Security Incidents

During 2017-18 there were two personal data-related incidents that met the Information Governance Serious Incidents Requiring Investigation (IG SIRI) criteria at Level 2 severity or above. Such incidents require reporting to the Information Commissioner's Office, Department of Health and Commissioners. The details of these incidents along with those of a lower (Level 1) severity, which do not meet the criteria for national reporting, can be found in the Trust's Annual Report, Quality Account and Financial Accounts 2017-18.

A summary of the two incidents reported this year are as follows:

- As a result of remedial action to rectify the access permissions to the HR network drive all files within the drive inadvertently became available to all YAS staff internally for a short period of time.
- The Trust created a folder on the network drive designed so that staff can temporarily collaborate with records that they would not normally have joint access to. It was found that staff had saved files in this folder that contained personally identifiable information and that these files remained in the folder after the collaboration had taken place.

Immediate action was taken to address the risks highlighted and further learning has been identified through the investigation process. The Trust has received outcomes from the ICO for both of the SIRI incidents, and no further action is required apart from completion of the Trust's internal action plan.

Annual Quality Account

The Trust Quality Account is developed through a process of extensive consultation both internally and with external stakeholders. The Quality Account for 2017/18 has been reviewed by the Trust Executive Group, the Board and its committees.

Data Quality

YAS did not submit records during 2017-18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. This requirement does not apply to ambulance trusts.

In 2017-18 YAS took the following actions to maintain and improve its data quality:

- The Information Asset Owners (IAOs) quarterly review process allows us to undertake data quality checks in their respective areas of the business.
- Staff training in the use of our systems that support the provision of care include the importance of accurate data input. Computer system functionality aims to support accurate data entry and data quality audits of both electronic and paper-based care records are undertaken, reported through the Trust's governance meeting cycle and support our Information Governance Toolkit submission. Feedback to staff is provided if and when data quality issues arise.
- Our Business Intelligence Team quality check all reports they produce and have procedures for undertaking data quality checks of external reports prior to distribution. The Trust continues to seek opportunities for continuous improvement in this area.
- Quarterly audits are undertaken to measure YAS adherence to the mandatory health records keeping standards in line with the Health Records Keeping Standards Policy.

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

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

- YAS will continue to work on the actions in the above section.

- Our internal auditors carried out an audit of the Trusts approach to data quality in 2016 which provided us with significant assurance with some minor improvements recommended to processes. An updated Audit will be scheduled in our 2018/19 plan.
- We will continue to raise awareness of data quality through the quarterly IAOs' review process to embed best practice and to strengthen the knowledge of our Information Asset Owners and Information Asset Administrators throughout the Trust.
- An electronic patient record (ePR) is currently being trialled that will provide better data quality and integrity by removing the need to scan documents or re-enter data from a manual form, which can lead to errors.
- Our Business Intelligence Team will continue to develop data quality reports for managers to help them monitor and improve data quality in their teams and have worked closely with our IT Department to improve data quality, developing data analysis reports which access a single source of data.
- There will be a review of the Data Quality Policy to ensure it remains fit for purpose.

YAS was not subject to the Payment by Results Clinical Coding Audit during 2017-18 by the Audit Commission.

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 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 board, the audit committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

- The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Board Assurance Framework and on the controls reviewed as part of the internal audit work.

- Executive Directors and senior managers within the organisation who are accountable for the development and maintenance of the system of internal control provide me with assurance.

- The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the key risks to the organisation achieving its principal objectives have been reviewed, which this year coming will be complemented by our strategic Assurance Map.

My review is also informed by:

- Care Quality Commission Fundamental Standards – Internal Compliance Assessments
- The Care Quality Commission inspection process where as a Trust we have received an overall Good rating across all service areas of the Trust in December 2016.
- The NHS Information Governance Toolkit.
- Assessment against NHS Counter Fraud and Security standards
- Peer reviews within the ambulance service sector
- Internal Audit reports
- External audit reports
- External consultancy reports on key aspects of Trust governance.
- Board Level Well Led self-assessment and the commissioning of an external Well Led review in line with national guidance.

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

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

- At least annually; a review of the effectiveness of the Trust's system of internal control
- The Trust Board ensures that the review covers all material controls, including financial, clinical, operational and compliance controls, and risk management systems
- A two yearly review of the Risk Management and Assurance Strategy
- Reviews in each Audit Committee meeting of the adequacy of assurances received by the Finance and Investment and Quality Committees in relation to the principal risks in the Board Assurance Framework that are assigned to them.
- A six monthly comprehensive review of the Board Assurance Framework
- Monthly integrated performance reports outlining achievement against key performance, safety and quality indicators
- Assurance reports at each meeting, providing information on progress against compliance with National Standards
- Assurance from internal and external audit reports that the Trust's risk management systems are being implemented

The risk assurance infrastructure closely scrutinises assurances on controls to assess their validity and efficiency.

A key element of this work is to ensure that all procedural documents are subject to monitoring compliance against the detail described within them; that they meet with regulatory requirements; and that they have considered all current legislation and guidance. Policy review and updates in line with national guidance are signed off through Trust Management Group on a monthly basis.

The Risk and Assurance Group carries out a detailed analysis of assurances received, to identify any gaps in the assurance mechanisms and to provide an evaluation of the effectiveness of them, reporting findings to executive committees/management groups as appropriate. The RAG reports directly into TMG via a formal monthly update provided by the Chair.

The Audit Committee consists of all of the Non-Executive Directors, with the exception of the Trust Chairman, with representatives of Internal and External Audit services in attendance. The Executive Director of Finance and Executive Director of Quality, Governance and Performance are in attendance at all meetings, with other Directors attending through the year as part of the Committee work programme. The Committee provides an overview and scrutiny of risk management. The Committee independently monitors, reviews and reports to the Trust Board on the processes of governance and, where appropriate, facilitates and supports through its independence, the attainment of effective processes.

The Audit Committee concludes upon the adequacy and effective operation of the organisation's overall internal control system.

In performing this role the Committee's work will predominantly focus upon the framework of risks, controls and related assurances that underpin the delivery of the organisation's objectives; the Board Assurance Framework.

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

The Audit Committee primarily utilises the work of internal audit, external audit and other assurance functions, but is not limited to these audit and assurance functions. It also seeks reports and assurances from other Board Committees, directors and managers as appropriate, concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness.

There is a robust process for the flow of information between the Finance and Investment Committee, Quality Committee and Audit Committee to support the assurance process on key risks.

The Quality Committee and Finance and Investment Committee have provided significant assurances to the Audit Committee on risks relevant to their terms of reference, covering all risks contained within the Board Assurance Framework. The Audit Committee completed its annual self-assessment of its' terms of reference in January 2018 and concluded that the arrangements in place were effective.

The Trust is required under NHS regulations to prepare a Quality Account for each financial year. The Trust Quality Account for 2017/18 reports on key indicators of quality relating to patient safety, clinical effectiveness and patient experience. The Quality Account includes comments from key stakeholders which are a positive reflection on developments over the year and of the Trust's engagement with partners. The Quality Account has been subject to independent external review by Ernst and Young (who are also the Trust's external auditors) and scrutiny by the

Audit Committee and I am satisfied that it presents a balanced and accurate view of quality within the Trust.

During 2016 the Trust received a full inspection from the Care Quality Commission under the revised regime of the Chief Inspector of Hospitals. The inspection took place in September 2016 for A&E and PTS and October for NHS 111. The full report was published in December 2016. The inspection found that the Trust has an overall rating of 'Good' across all domains and highlighted improvements had been made throughout the service lines. The Trust received an "outstanding" rating in the 'Caring' domain as part of the overall assessment.

The trust received three "must do's" in the report as follows:

- Ensure there are sufficient numbers of suitably skilled, qualified and experienced staff.
- Ensure all PTS ambulances and equipment are appropriately cleaned and Infection Prevention Control procedures followed.
- Ensure appropriate seating for children is routinely available in ambulance vehicles.

The action plan has been implemented to address the issues highlighted, with oversight by the Trust Executive Group and regular assurance on progress to the Board, commissioners and NHSI as appropriate. The Trust anticipates that it will have a follow up inspection in Q2/Q3 of 2018/19.

On final review and closure of the 2017/18 iteration of the Board Assurance Framework, a significant issue has been identified relating to delivery of the newly defined ARP response standards by September 2018, as stipulated in the revised Planning Guidance. It is recognised that delivery of the new standards and realisation of the benefits for patients, will require significant additional investment and large scale service transformation. It is also acknowledged that this must be delivered in a challenging context of rising demand, clinical workforce constraints, wider system changes and Emergency Department turnaround pressures at a number of sites. Extensive discussions have been held with commissioners in relation to the requirements and anticipated milestones for delivery, and mitigation plans are in place to address this challenge during 2018/19.

Conclusion

No significant internal control issues have been identified.

Signed.....

Chief Executive Date: May 2018

2. Head of Internal Audit Opinion for the year ended 31 March 2018

2.1 Introduction

In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit is required to provide an annual opinion on the overall adequacy and effectiveness of the organisation's system of internal control.

The purpose of this report is to provide the Audit Committee with the Head of Internal Audit Opinion for the year ended 31 March 2018, which should be used to inform the Annual Governance Statement.

2.2 Roles and responsibilities

The Accountable Officer is responsible for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.
The Annual Governance Statement is an annual statement by the Accountable Officer, on behalf of the Governing Body, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process;
- the conduct and results of the review of the effectiveness of the system of internal control, including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

The organisation's Assurance Framework should bring together all of the evidence required to support the Annual Governance Statement requirements.

In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit is required to provide an annual opinion, based upon, and limited to, the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This is achieved through a risk-based plan of work, approved by Audit Committee, which should provide a reasonable level of assurance, subject to the inherent limitations described below.

The opinion does not imply that Internal Audit have reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans, generated from a robust and organisation-led Assurance Framework. As such, it is one component that the Accountable Officer takes into account in making the Annual Governance Statement. The Accountable Officer will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement.

2.3 The Head of Internal Audit Opinion

The purpose of my annual Head of Internal Audit Opinion is to contribute to the assurances available to the Accountable Officer and the Governing Body which underpins the organisation's own assessment of the effectiveness of the system of internal control. This Opinion will in turn assist in the completion of the Annual Governance Statement.

My opinion is set out as follows:

2.3.1 Overall opinion;
2.3.2 Basis for the opinion;
2.3.3 Commentary.

2.3.1 Overall Opinion

From my review of your systems of internal control, I am providing good assurance that there is a sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

2.3.2 Basis of the Opinion

The basis for forming my opinion is as follows:

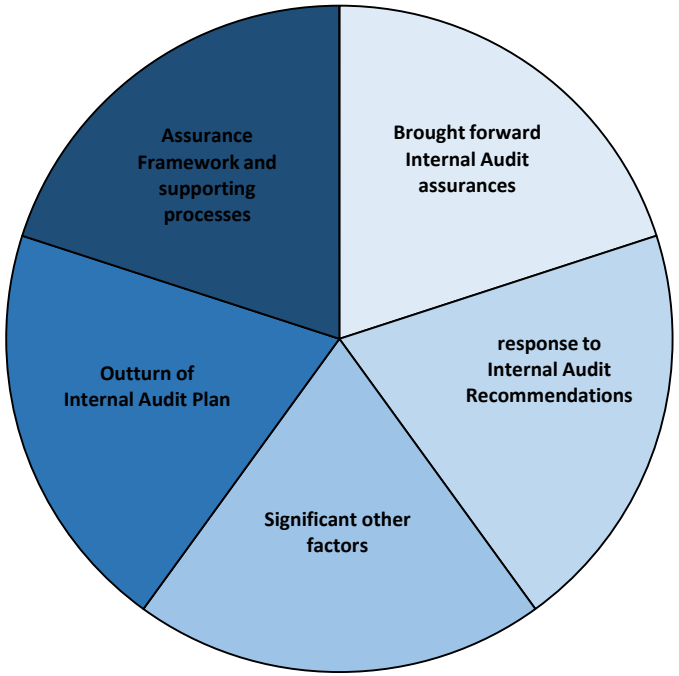
1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes for governance and the management of risk;

2. An assessment of the range of individual opinions arising from audit assignments, contained within risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses;

3. Brought forward Internal Audit assurances;

4. An assessment of the organisation's response to Internal Audit recommendations, and

5. Consideration of significant factors outside the work of Internal Audit.



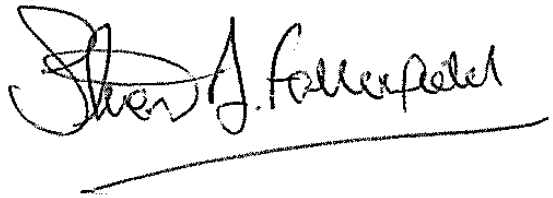
2.3.3 Commentary

Opinion Area	Commentary
Design and operation of the Assurance Framework and supporting processes	An Assurance Framework (BAF) exists to meet the requirements of the Annual Governance Statement and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation. The BAF aligns the Trust's Strategic Objectives and Goals to the principal risks in achieving them. The Trust has continued to ensure that the BAF is used at Board level, with support from the key governance committees.
Outturn of Internal Audit Plan	A table of individual opinions arising from audit assignments reported throughout the year is contained in Appendix A. Definitions of individual opinions are given at Appendix B. At the time of producing this opinion summary we have issued 20 final / draft reports with a split of: 2 Substantial Assurance 14 Good Assurance 3 Reasonable Assurance 0 Limited Assurance 1 No assurance level provided In addition to those identified above, fieldwork is being completed for a further four pieces of work. Two advisory reports were also issued.. In preparing this opinion, there are no significant control weaknesses that we recommend should be specifically referenced in the Annual Governance Statement, however we would wish to bring to the attention of the Accountable Officer the following reports issued during the year which have

	been assigned a 'reasonable' or 'limited' assurance opinion, or related to matters of significant importance for potential inclusion in the AGS are as follows; **Resource Management (end of shift overtime) Follow Up (Ref:181117)** This follow up audit of end of shift overtime found that progress had been made in terms of some aspects of the recommendations, however there was still a high-level recommendation made since evidence was not available to demonstrate that the required checks are consistently being carried out to validate the hours being claimed. Management have agreed to re-write the SOP to be clearer about how these checks are reported and monitored internally and had already planned the production of several dashboards for Locality Managers and Clinical Supervisors to use, supported by relevant training. **Performance Management KPIs (Ref:181122)** The objective of the audit was to evaluate the design and test the application of controls surrounding the reporting of KPIs. However, the audit revealed that there are no Standard Operating Procedures (SOPs) in place for any of the four KPIs reviewed. In terms of the sample of KPIs we identified for the audit, we met with various people to ascertain what the systems were for the capture of source data, with the expectation that we could then trace this through the various processes and systems to the point where it is reported against a KPI. However, due to the fact that the processes were not documented, there are known issues with data quality in some areas (e.g. sickness) and data flows are complex and inconsistent, it became clear that it would take a considerable amount of time to formally evaluate the specific risks and causes set out in the audit planning memorandum and that, even if we undertook any more work, the assurance level would still be reasonable. We therefore did not undertake any further work but made a high-level recommendation that SOPs should be compiled covering production of KPI indicators. This is a fundamental requirement in terms of data quality and the well led framework. **Inspections for Improvement (Ref:181130)** We provided reasonable assurance as a result of this audit as whilst the process for undertaking the inspections is comprehensive and well documented, the responsibilities for those required to implement the actions are not formalised nor necessarily understood and actions are not always being implemented in line with the timescales suggested on the action plan. Particularly with regards to Estates. It is also important that processes for escalating issues and provide assurance to TMG and the Quality Committee are agreed and documented. **Information Governance Toolkit (Ref: 111318)**

	Whilst we did not assign an overall assurance level to this audit, we did make three recommendations as a result of the work undertaken. The key one related to the need to ensure that the Trust can demonstrate that 95% of staff have completed their IG training before 31st March 2018. At the time of issuing the final IG toolkit audit report we had not been provided with that evidence and were therefore unable to substantiate the level 2 compliance that the Trust submitted for that requirement.
Brought forward Internal Audit assurances	The overall opinion for 2016/2017 was: '**Significant Assurance** can be given that there is generally a sound system of internal control designed to meet the organisations objectives and that controls are generally being applied consistently. However, some weaknesses in the design or inconsistent application of controls put the achievement of objectives at risk, most notably in the areas of community first responders, fleet management and the level of implementation of required improvements to end of shift overtime management, temporary staffing and consultant recruitment processes and HR process compliance including MARS'. There was also an audit of Fit and Proper Persons finalised after the Annual Report was issued last year that provided limited assurance due to a number of issues being identified.
Response to Internal Audit recommendations	There were three high graded recommendations made during the year in the following reports: - Resource Management – as indicated above. Not due for implementation until September 2018 - Performance Management KPI's – as indicated above. An implementation date for this is still to be agreed as the report is in draft format. - Inspections for Improvement – as indicated above. Not due for implementation until June 2018.
Significant factors outside the work of internal audit	None.

I would like to take this opportunity to thank the staff at Yorkshire Ambulance Service NHS Trust for the co-operation and assistance provided to my team during the year.



Stuart Fallowfield
Director of Internal Audit, AuditOne
Date: May 2018

Statement of Chief Executive and Directors' responsibilties

Statement of the chief executive's responsibilities as the accountable officer of the trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, 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, recognised gains and losses and cash flows for the year.

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

Signed.....Rod Barnes, Chief Executive

Date.....24/5/2018.....

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, recognised gains and losses and cash flows for the year. In preparing those accounts, the directors are required to:

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

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

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

By order of the Board

24/5/2018 ....Date.....Rod Barnes, Chief Executive

24-5-18 .....Date.....Mark Bradley, Finance Director

Independent Auditor's Statement

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF Yorkshire Ambulance Service NHS Trust

Opinion

We have audited the financial statements of Yorkshire Ambulance Service NHS Trust for the year ended 31 March 2018 under the Local Audit and Accountability Act 2014. The financial statements comprise the Trust's Statement of Comprehensive Income, the Trust Statement of Financial Position, the Trust Statement of Changes in Taxpayers' Equity, the Trust Statement of Cash Flows and the related notes 1 to 34. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2017-18 HM Treasury's Financial Reporting Manual (the 2017-18 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2017/18 and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England (the Accounts Direction).

In our opinion the financial statements:

- give a true and fair view of the financial position of Yorkshire Ambulance Service NHS Trust as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the National Health Service Act 2006 and the Accounts Directions issued thereunder.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report below. 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 FRC's Ethical Standard and the Comptroller and Auditor General's (C&AG) AGN01 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.

Use of our report

This report is made solely to the Board of Directors of Yorkshire Ambulance Service NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014 and for no other purpose. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Directors, for our audit work, for this report, or for the opinions we have formed.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the directors use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

The other information comprises the information included in the annual report set out on pages 1 to 96, other than the financial statements and our auditor's report thereon. The directors are 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 this report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, 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 there is 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 the other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters prescribed by the Health Services Act 2006

In our opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with the Health Services Act 2006 and the Accounts Directions issued thereunder.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the NHS Improvement's guidance; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014; or
- we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

We have nothing to report in these respects

Responsibilities of the Directors and Accountable Officer

As explained more fully in the Statement of Directors' Responsibilities in respect of the Accounts, set out on page 99, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. In preparing the financial statements, the Accountable Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accountable Officer either intends to cease operations, or have no realistic alternative but to do so

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibility 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.

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in August 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary

for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Certificate

We certify that we have completed the audit of the accounts of Yorkshire Ambulance Service NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Hassan Rohlmun (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Manchester
24 May 2018

The maintenance and integrity of the **Yorkshire Ambulance Service NHS Trust** web site is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web site.
Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Financial Accounts 2017-18

Statement of Comprehensive Income for the year ended 31 March 2018

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	259,211	248,934
Other operating income	4	10,240	6,490
Operating expenses	6, 8	(257,660)	(250,601)
Operating surplus from continuing operations		**11,791**	**4,823**
Finance income	11	84	52
Finance expenses	12	(126)	(231)
PDC dividends payable		(2,049)	(2,111)
Net finance costs		**(2,091)**	**(2,290)**
Other gains	13	165	180
Surplus for the year		**9,865**	**2,713**
Other comprehensive income			
Revaluations (not reclassified to income or expenditure)	15	3,978	103
Total comprehensive income for the period		**13,843**	**2,816**
Financial performance for the year			
Retained surplus for the year		**9,865**	**2,713**
Impairments	7	**283**	**0**
Adjustments in respect of donated asset impact		**6**	**6**
CQUIN reserve adjustment		**(850)**	
Adjusted financial performance surplus		**9,304**	**2,719**
STF included in above		(5,320)	(1,140)
Financial performance surplus before additional income		**3,984**	**1,579**

The notes on pages 110 to 148 form part of these accounts.

Statement of Financial Position for the year ended 31 March 2018

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	14	1,267	1,273
Property, plant and equipment	15	90,348	89,469
Trade and other receivables	17	561	603
Total non-current assets		**92,176**	**91,345**
Current assets			
Inventories	16	1,330	1,299
Trade and other receivables	17	16,321	9,434
Non-current assets held for sale / assets in disposal groups	18	935	160
Cash and cash equivalents	19	30,165	19,085
Total current assets		**48,751**	**29,978**
Current liabilities			
Trade and other payables	20	(18,767)	(13,655)
Borrowings	22	(334)	(823)
Provisions	23	(5,580)	(2,889)
Other liabilities	21	(134)	(178)
Total current liabilities		**(24,815)**	**(17,545)**
Total assets less current liabilities		**116,112**	**103,778**
Non-current liabilities			
Borrowings	22	(4,501)	(5,813)
Provisions	23	(9,247)	(9,575)
Total non-current liabilities		**(13,748)**	**(15,388)**
Total assets employed		**102,364**	**88,390**
Financed by			
Public dividend capital		75,168	75,037
Revaluation reserve		14,776	9,501
Income and expenditure reserve		12,420	3,852
Total taxpayers' equity		**102,364**	**88,390**

The notes on pages 110 to 148 form part of these accounts.

The financial statements on pages 104 to 109 were approved by the Board on 24th May 2018

Chief Executive:  **Date:** 24/5/2018

Rod Barnes

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**75,037**	**9,501**	**3,852**	**88,390**
Surplus/(deficit) for the year	-	-	9,865	**9,865**
Other transfers between reserves	-	1,351	(1,351)	**-**
Revaluations	-	3,978	-	**3,978**
Transfer to retained earnings on disposal of assets	-	(54)	54	**-**
Public dividend capital received	131	-	-	**131**
Taxpayers' equity at 31 March 2018	**75,168**	**14,776**	**12,420**	**102,364**

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	**74,941**	**9,890**	**647**	**85,478**
Prior period adjustment	-	-	-	**-**
Taxpayers' equity at 1 April 2016 - restated	**74,941**	**9,890**	**647**	**85,478**
Surplus/(deficit) for the year	-	-	2,713	**2,713**
Other transfers between reserves	-	(492)	492	**-**
Revaluations	-	103	-	**103**
Public dividend capital received	96	-	-	**96**
Taxpayers' equity at 31 March 2017	**75,037**	**9,501**	**3,852**	**88,390**

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 for the year ended 31 March 2018

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		11,791	4,823
Non-cash income and expense:			
Depreciation and amortisation	6	9,418	9,082
Net impairments	7	283	-
(Increase) / decrease in receivables and other assets		(6,970)	1,528
(Increase) / decrease in inventories		(31)	(223)
Increase / (decrease) in payables and other liabilties		4,979	(3,476)
Increase / (decrease) in provisions		2,341	1,612
Net cash generated from / (used in) operating activities		**21,811**	**13,346**
Cash flows from investing activities			
Interest received		84	52
Purchase of intangible assets		(492)	(287)
Purchase of property, plant, equipment and investment property		(7,016)	(13,737)
Sales of property, plant, equipment and investment property		355	953
Net cash generated from / (used in) investing activities		**(7,069)**	**(13,019)**
Cash flows from financing activities			
Public dividend capital received		131	96
Movement on loans from the Department of Health and Social Care		(1,801)	(823)
Other interest paid		(106)	(116)
PDC dividend (paid) / refunded		(1,886)	(1,868)
Net cash generated from / (used in) financing activities		**(3,662)**	**(2,711)**
Increase / (decrease) in cash and cash equivalents		**11,080**	**(2,384)**
Cash and cash equivalents at 1 April - brought forward		**19,085**	**21,469**
Cash and cash equivalents at 31 March	19	**30,165**	**19,085**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of 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 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the 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 accounts.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.1.2 Going concern

After making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason the accounts have been prepared on a going concern basis

Note 1.2 Critical judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Note 1.2.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

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 1.2.2 Sources of estimation uncertainty

Non Current Assets.

Values are as disclosed in notes 15.1 tangible assets, and 14.1 intangible assets.

Asset lives, with the exception of buildings are set out in note 1.7.5 and note 1.8.3, with maximum lives being set by reference to the type of asset and its expected useful life in normal use. Building lives are based on the recommendations received from the District Valuer.

Land and buildings have been re-valued as at 31 March 2018 and have not been subject to indexation in the year. The results of this are disclosed in note 15.1.

Provisions.

Values are as disclosed in note 23.1.

These have been estimated based on the best information available at the time of the compilation of the accounts.

Estimates of employee's legal claims are made including the advice received from the NHS Resolution to the size and likely outcome of each individual claim. The Trust's maximum liability regarding each claim is limited to £10k.
We have provided for the costs of reinstating dilapidations to leased and tenancy properties based on a professional evaluation by Lambert Smith Hampton.
We have provided for the costs of reinstating dilapidations to leased vehicles based on the historic costs of undertaking that work.

Provision for impairment of receivables (note 17.2)
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.

Note 1.4 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of health care services.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives the funds from the Department of Work and Pension's Compensation Recovery Unit. The income is measured at the agreed tariff for the transport provided to the injured individual.

Revenue grants and other contributions to expenditure
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.

The value of the benefit received when accessing funds from the 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, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 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 NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. There, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost 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.

National Employment Savings Trust (NEST)
There are a small number of staff who are not entitled to join the NHS pension scheme, for example:

- Those already in receipt of an NHS pension who have taken benefits from the 1995 section of the scheme;
- Those who work full time at another Trust;
- Those over 75 years of age

The National Employment Savings Trust (NEST) has been set up specifically to help employers to comply with the Pensions Act 2008. Employees who have taken their benefits from the 1995 section of the NHS pension scheme and are under state retirement age are enrolled in the NEST scheme. NEST Corporation is the Trustee body that has overall responsibility for running NEST; it is a non-departmental public body that operates at arm's length from government and is accountable to Parliament through the Department of Work and Pensions (DWP).

In 2017-18 employee contributions to NEST were 0.8% of pensionable pay and employer contributions were also 1.0% of pensionable pay. NEST levies a contribution charge of 1.8% and an annual management charge of 0.3% which is paid for from the employee contributions. There are no separate employer charges levied by NEST and the Trust is not required to enter into a contract to utilise NEST qualifying pension schemes.

Note 1.6 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 1.7 Property, plant and equipment

Note 1.7.1 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, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Note 1.7.2 Measurement
Valuation
All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.
Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:
• Land and non-specialised buildings – market value for existing use.
• Specialised buildings – depreciated replacement cost, modern equivalent asset basis.
HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.
Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.
An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure
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.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification.

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 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'.

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.

Note 1.7.3 Derecognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable ie:

- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

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. Assets are de-recognised when 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 economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 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.

Note 1.7.5 Useful economic lives of property, plant and equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Buildings excluding dwellings	5	48
Plant & machinery	5	15
Transport equipment	3	7
Information technology	2	7
Furniture & fittings	4	10

Note 1.8 Intangible assets

Note 1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They 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.

Software

Software which is integral to the operation of hardware, eg 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, eg application software, is capitalised as an intangible asset.

Note 1.8.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8.3 Useful economic lives of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Software licences	2	7

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Note 1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the trusts cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.11 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for 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, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as "fair value through income and expenditure", loans and receivables or "available-for-sale financial assets".

Financial liabilities are classified as "fair value through income and expenditure" or as "other financial liabilities".

Financial assets and financial liabilities at "fair value through income and expenditure"

Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS receivables, accrued income and "other receivables".

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Financial liabilities
All financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets
At the Statement of Financial Position date, the trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

Note 1.12 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.12.1 The trust as lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.13 Provisions

The trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; 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 the discount rates published and mandated by HM Treasury.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. 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 23.2 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 1.14 Contingencies
Contingent liabilities are not recognised, but are disclosed in note 23, 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.

Note 1.15 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.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

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, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

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 thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.16 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 1.17 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.18 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations

Note 1.18 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 2. Operating Segments

The Trust has judged that it only operates as one business segment; that of healthcare. 96% (£258m) of the Trust's income in 2017/18 (16/17 97%, £248m) is received form NHS oganisations

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	2017/18	2016/17
	£000	£000
Ambulance services		
A & E income	188,349	179,169
Patient transport services income	30,272	28,968
Other income	40,590	40,797
Total income from activities	**259,211**	**248,934**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18	2016/17
	£000	£000
NHS England	2,099	1,918
Clinical commissioning groups	255,108	245,183
Other NHS providers	1,059	857
Local authorities	10	-
Non-NHS: private patients	14	12
NHS injury scheme	887	964
Non NHS: other	34	-
Total income from activities	**259,211**	**248,934**
Of which:		
Related to continuing operations	259,211	248,934

Note 4 Other operating income

	2017/18	2016/17
	£000	£000
Research and development	234	221
Education and training	1,752	1,899
Sustainability and transformation fund income	5,320	1,140
Income in respect of staff costs where accounted on gross basis	630	563
Other income	2,304	2,667
Total other operating income	**10,240**	**6,490**
Of which:		
Related to continuing operations	10,240	6,490

Note 5 Fees and charges

The Trust undertakes income generation activities with an aim of achieving a surplus, which is then used in the delivery of patient care. The Trust does not have any income generation schemes where costs exceed £1m.

Note 6.1 Operating expenses

	2017/18 £000	2016/17 £000
Purchase of healthcare from NHS and DHSC bodies	185	185
Purchase of healthcare from non-NHS and non-DHSC bodies	19,382	22,137
Staff and executive directors costs	174,898	170,973
Remuneration of non-executive directors	82	68
Supplies and services - clinical (excluding drugs costs)	6,080	4,782
Supplies and services - general	1,628	1,333
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	295	355
Consultancy costs	546	977
Establishment	5,410	6,173
Premises	11,154	7,676
Transport (including patient travel)	16,945	15,194
Depreciation on property, plant and equipment	8,868	8,569
Amortisation on intangible assets	550	513
Net impairments	283	-
Increase in provision for impairment of receivables	56	29
Change in provisions discount rate(s)	187	1,015
Audit fees payable to the external auditor		
audit services- statutory audit	68	73
other auditor remuneration (external auditor only)	-	30
Internal audit costs	145	192
Clinical negligence	1,143	1,063
Legal fees	1,270	244
Insurance	3,209	2,289
Education and training	1,767	1,505
Rentals under operating leases	2,808	2,683
Early retirements	-	-
Redundancy	235	143
Hospitality	277	555
Losses, ex gratia & special payments	125	96
Other	64	1,749
Total	**257,660**	**250,601**
Of which:		
Related to continuing operations	257,660	250,601

The cost of statutory audit services for 2016-17 has been restated to include VAT

Note 6.2 Other auditor remuneration

	2017/18 £000	2016/17 £000
Other auditor remuneration paid to the external auditor:		
VAT services	-	30
Total	**-**	**30**

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2016/17: £0m).
The limitation on auditor's responsibility for 2017/18 reflects the fact that this is the first period in which the external audit has been completed outside of the PSAA contract terms and conditions.

Note 7 Impairment of assets

	2017/18 £000	2016/17 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	274	-
Other	9	-
Total net impairments charged to operating surplus / deficit	**283**	**-**

Note 8 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	140,203	134,584
Social security costs	13,714	13,247
Apprenticeship levy	683	-
Employer's contributions to NHS pensions	17,111	16,244
Termination benefits	235	349
Temporary staff (including agency)	3,187	6,692
Total staff costs	**175,133**	**171,116**

No staff costs were capitalised as part of assets during the 2017-18 financial year.

Note 8.1 Retirements due to ill-health

During 2017/18 there were 11 early retirements from the trust agreed on the grounds of ill-health (4 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £920k (£168k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 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 report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Note 10 Operating leases

Note 10.1 Yorkshire Ambulance Service NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Yorkshire Ambulance Service NHS Trust is the lessee.

The Trust's operating lease commitments relate to land, buildings, medical equipment and vehicles.

The vehicle commitments are based on 433 vehicles, of which 172 are due to expire within 1 year and 259 are due to expire between 1 and 5 years.

The commitment on land consists of 2 leases which is for the car parking facility at the Springhill Headquarters and Fleet Unit M which are due to expire between 1 and 5 years. The commitment on land and buildings consists of 41 leases, of which 3 are due to expire after 5 years, 8 will expire between 1 and 5 years, and 30 will expire within 1 year.

	2017/18	2016/17
	£000	£000
Operating lease expense		
Minimum lease payments	2,808	2,683
Total	**2,808**	**2,683**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease payments due:		
- not later than one year;	1,296	1,556
- later than one year and not later than five years;	5,049	2,934
- later than five years.	1,022	916
Total	**7,367**	**5,406**

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2017/18	2016/17
	£000	£000
Interest on bank accounts	84	52
Total	**84**	**52**

Note 12.1 Finance expenditure

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

	2017/18	2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	104	116
Total interest expense	**104**	**116**
Unwinding of discount on provisions	22	115
Total finance costs	**126**	**231**

Note 13 Other gains

	2017/18	2016/17
	£000	£000
Gains on disposal of assets	165	180
Total other gains	**165**	**180**

Note 14 Intangible Assets

Intangible non current assets relate to purchased software licences which are valued at purchase cost less accumulated amortisation. Asset lives range between 2 and 7 years with no asset having an indefinite life given software is constantly being updated.

Note 14.1 Intangible assets - 2017/18

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**3,359**	**211**	**3,570**
Additions	378	166	**544**
Reclassifications	211	(211)	**-**
Disposals / derecognition	(591)	-	**(591)**
Gross cost at 31 March 2018	**3,357**	**166**	**3,523**
Amortisation at 1 April 2017 - brought forward	**2,297**	**-**	**2,297**
Provided during the year	550	-	**550**
Disposals / derecognition	**(591)**	**-**	**(591)**
Amortisation at 31 March 2018	**2,256**	**-**	**2,256**
Net book value at 31 March 2018	**1,101**	**166**	**1,267**
Net book value at 1 April 2017	**1,062**	**211**	**1,273**

Note 14.2 Intangible assets - 2016/17

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**2,917**	**-**	**2,917**
Additions	194	459	**653**
Reclassifications	248	(248)	**-**
Valuation / gross cost at 31 March 2017	**3,359**	**211**	**3,570**
Amortisation at 1 April 2016 - as previously stated	**1,784**	**-**	**1,784**
Provided during the year	**513**	**-**	**513**
Amortisation at 31 March 2017	**2,297**	**-**	**2,297**
Net book value at 31 March 2017	**1,062**	**211**	**1,273**
Net book value at 1 April 2016	**1,133**	**-**	**1,133**

Note 15.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**19,079**	**35,172**	**6,503**	**6,372**	**57,225**	**30,444**	**813**	**155,608**
Additions	-	399	3,379	2,327	506	406	-	**7,017**
Impairments	(23)	(283)	-	-	-	-	-	**(306)**
Reversals of impairments	-	32	-	-	-	-	-	**32**
Revaluations	-	2,751	-	-	-	-	-	**2,751**
Reclassifications	-	243	(5,149)	4	4,871	31	-	**-**
Transfers to/ from assets held for sale	(250)	(525)	-	-	-	-	-	**(775)**
Disposals / derecognition (see note below)	-	-	-	(334)	(14,148)	(19,740)	(127)	**(34,349)**
Valuation/gross cost at 31 March 2018	**18,806**	**37,789**	**4,733**	**8,369**	**48,454**	**11,141**	**686**	**129,978**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	-	-	2,497	37,297	25,687	658	**66,139**
Provided during the year	**-**	1,227	-	640	5,491	1,487	23	**8,868**
Impairments	-	-	-	5	3	1	-	**9**
Revaluations	-	(1,227)	-	-	-	-	-	**(1,227)**
Disposals / derecognition (see note below)	-	-	-	(334)	(13,958)	(19,740)	(127)	**(34,159)**
Accumulated depreciation at 31 March 2018	**-**	**-**	**-**	**2,808**	**28,833**	**7,435**	**554**	**39,630**
Net book value at 31 March 2018	**18,806**	**37,789**	**4,733**	**5,561**	**19,621**	**3,706**	**132**	**90,348**
Net book value at 1 April 2017	**19,079**	**35,172**	**6,503**	**3,875**	**19,928**	**4,757**	**155**	**89,469**

Note on disposals / derecognition. Following an internal review, we have identified assets with a gross cost of £27.8m and a net book value of £0m that were no longer in use. These have now been removed from the fixed asset register.

Note 15.2 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**19,229**	**35,306**	**6,112**	**3,634**	**56,408**	**28,353**	**813**	**149,855**
Additions	-	690	5,784	2,618	2,239	691	-	**12,022**
Revaluations	(139)	(937)	-	-	-	-	-	**(1,076)**
Reclassifications	-	113	(5,393)	120	3,758	1,402	-	**-**
Disposals / derecognition	(11)	-	-	-	(5,180)	(2)	-	**(5,193)**
Valuation/gross cost at 31 March 2017	**19,079**	**35,172**	**6,503**	**6,372**	**57,225**	**30,444**	**813**	**155,608**
Accumulated depreciation at 1 April 2016 - as previously stated	**-**	**-**	**-**	**2,167**	**36,998**	**23,994**	**635**	**63,794**
Provided during the year	**-**	**1,179**	**-**	**330**	**5,342**	**1,695**	**23**	**8,569**
Revaluations	-	(1,179)	-	-	-	-	-	**(1,179)**
Disposals/ derecognition	-	-	-	-	(5,043)	(2)	-	**(5,045)**
Accumulated depreciation at 31 March 2017	**-**	**-**	**-**	**2,497**	**37,297**	**25,687**	**658**	**66,139**
Net book value at 31 March 2017	**19,079**	**35,172**	**6,503**	**3,875**	**19,928**	**4,757**	**155**	**89,469**
Net book value at 1 April 2016	**19,229**	**35,306**	**6,112**	**1,467**	**19,410**	**4,359**	**178**	**86,061**

All valuations of Land and buildings are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Valuation Standards. The Trust's land and buildings valuations were undertaken by the District Valuer Service, part of the Valuation Office Agency of HM Revenue and Customs during January 2018 with a prospective valuation date of 31 March 2018. Valuations are carried out on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property. There are a net £274k of impairments as a result of these valuation due to changes in market price.

Note 15.3 Property, plant and equipment donated assets - 2017/18

The Trust has two donated assets, both are community medical units.
The assets were added to the asset register at NBV at the time of the donation.
The asset have been internally assessed to have an expected life of 5 years.

Note 15.4 Property, plant and equipment financing - 2017/18

	Land	Buildings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018								
Owned - purchased	18,806	37,789	4,733	5,561	19,617	3,706	132	**90,344**
Owned - donated	-	-	-	-	4	-	-	**4**
NBV total at 31 March 2018	**18,806**	**37,789**	**4,733**	**5,561**	**19,621**	**3,706**	**132**	**90,348**

Note 15.4 Property, plant and equipment financing - 2016/17

	Land	Buildings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017								
Owned - purchased	19,079	35,172	6,503	3,875	19,918	4,757	155	**89,459**
Owned - donated	-	-	-	-	10	-	-	**10**
NBV total at 31 March 2017	**19,079**	**35,172**	**6,503**	**3,875**	**19,928**	**4,757**	**155**	**89,469**

Note 16 Inventories

	31 March 2018 £000	31 March 2017 £000
Drugs	74	74
Consumables	1,085	1,076
Other	171	149
Total inventories	**1,330**	**1,299**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £12,622k (2016/17: £11,555k). Write-down of inventories recognised as expenses for the year were £0k (2016/17: £0k).

Note 17.1 Trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	3,555	2,769
Accrued income	7,597	1,687
Provision for impaired receivables	(562)	(532)
Prepayments (non-PFI)	5,206	4,751
PDC dividend receivable	-	125
VAT receivable	319	240
Other receivables	206	394
Total current trade and other receivables	**16,321**	**9,434**
Non-current		
Accrued income	561	603
Total non-current trade and other receivables	**561**	**603**
Of which receivables from NHS and DHSC group bodies:		
Current	9,041	3,455
Non-current	-	-

Note 17.2 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	**532**	**505**
Increase in provision	56	29
Amounts utilised	(26)	(2)
At 31 March	**562**	**532**

Provision is made for non-NHS receivables that are 90 days or more past due, where no agreement has been reached for payment.
NHS bodies are not expected to default on their liabilities, and therefore no provision is made for amounts due from NHS bodies.

Note 17.3 Credit quality of financial assets

	31 March 2018	31 March 2017
Ageing of impaired financial assets	**Trade and other receivables £000**	**Trade and other receivables £000**
0 - 30 days	-	-
30-60 Days	-	-
60-90 days	-	-
90- 180 days	26	24
Over 180 days	73	36
Total	**99**	**60**
Ageing of non-impaired financial assets past their due date		
0 - 30 days	118	355
30-60 Days	86	120
60-90 days	7	163
90- 180 days	293	421
Over 180 days	963	945
Total	**1,467**	**2,004**

The great majority of trade is with Clinical Commissioning Groups (CCGs). As CCGs are funded by Government to buy NHS patient care no credit scoring of them is considered necessary

Note 18 Non-current assets held for sale and assets in disposal groups

	2017/18 £000	2016/17 £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**160**	**785**
Assets classified as available for sale in the year	775	**-**
Assets sold in year	-	**(625)**
NBV of non-current assets for sale and assets in disposal groups at 31 March	**935**	**160**

The assets held for sale in year were Bramham, a former ambulance station and the Administration Centre South (otherwise known as Fairfield), a support services building.

The former is part of a tri-party multi agency disposal event which is expected to take place during the course of the financial year 2018/19. The latter was approved for disposal by the Trust Board in 2017/18 and the disposal is expected to take place in the first quarter of 2018/19.

Note 19 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.

	2017/18	2016/17
	£000	£000
At 1 April	**19,085**	**21,469**
Net change in year	11,080	(2,384)
At 31 March	**30,165**	**19,085**
Broken down into:		
Cash at commercial banks and in hand	26	43
Cash with the Government Banking Service	30,139	19,042
Total cash and cash equivalents as in SoFP	**30,165**	**19,085**
Total cash and cash equivalents as in SoCF	**30,165**	**19,085**

Note 19.1 Third party assets held by the trust

The trust does not hold cash or cash equivalents on behalf of patients or other parties.

Note 20 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	6,818	2,219
Capital payables	1,948	1,895
Accruals	7,715	7,185
Receipts in advance (including payments on account)	-	-
Social security costs	15	-
VAT payables	-	-
Other taxes payable	5	201
PDC dividend payable	38	-
Accrued interest on loans	4	6
Other payables	2,224	2,149
Total current trade and other payables	**18,767**	**13,655**
Of which payables from NHS and DHSC group bodies:		
Current	306	301

Note 20.1 Pension costs in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2018 £000	31 March 2017 £000
Outstanding pension contributions	2,224	2,149

There were no amounts payable in relation to early retirements.

Note 21 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	134	178
Total other current liabilities	**134**	**178**

Note 22 Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Loans from the Department of Health and Social Care	334	823
Total current borrowings	**334**	**823**
Non-current		
Loans from the Department of Health and Social Care	4,501	5,813
Total non-current borrowings	**4,501**	**5,813**

During 2017-18 the Trust repaid the outstanding principal, £977,900, on one of the two loans from the Department of Health and Social Care.

Note 23.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Legal claims	Re-structuring	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2017	**9,116**	**595**	**358**	**2,395**	**12,464**
Change in the discount rate	112	-	-	75	**187**
Arising during the year	392	349	6	3,868	**4,615**
Utilised during the year	(507)	(335)	(215)	(160)	**(1,217)**
Reclassified to liabilities held in disposal groups	-	-	-	-	**-**
Reversed unused	(829)	(91)	(143)	(181)	**(1,244)**
Unwinding of discount	22	-	-	-	**22**
At 31 March 2018	**8,306**	**518**	**6**	**5,997**	**14,827**
Expected timing of cash flows:					
- not later than one year;	510	518	6	4,546	**5,580**
- later than one year and not later than five years;	2,037	-	-	1,451	**3,488**
- later than five years.	5,759	-	-	-	**5,759**
Total	**8,306**	**518**	**6**	**5,997**	**14,827**

Amount Included in the Provisions of the NHS Resolution in Respect of Clinical Negligence Liabilities:

As at 31 March 2018	4,817
As at 31 March 2017	6,764

Restructuring provisions have been made in respect of reorganisations within Corporate Services.
'Other' provisions comprise:
Provision for staff costs including ‘Frozen Leave’ costs, debts outstanding on the Salary Sacrifice Scheme for Cars, and holiday pay
Provision for anticipated dilapidation costs: for leased buildings based on an independent assessment by Lambert Smith Hampton, and for leased vehicles based on past costs of restoration.
Provisions for costs arising from legal cases and for employment tribunals.

Note 23.2 Clinical negligence liabilities

At 31 March 2018, £4,817k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Yorkshire Ambulance Service NHS Trust (31 March 2017: £6,764k).

Note 24 Contingent liabilities

	31 March 2018 £000	31 March 2017 £000
Total contingent liabilities	**339**	**389**

All contingent liabilities relate to legal claims against the trust. These are managed by NHS Resolution on behalf of the trust. The amount included reflects advice from that body.

Note 25 Contractual capital commitments

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	510	153
Intangible assets	34	7
Total	**544**	**160**

Note 26 Other financial commitments

The trust is not committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement).

Note 27 Financial instruments

Note 27.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Trust's Management Board. Treasury activity is subject to review by the Trust's internal auditors.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk
The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk
Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk
The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 27.2 Carrying values of financial assets

	Loans and receivables	Total book value
	£000	£000
Assets as per SoFP as at 31 March 2018		
Trade and other receivables excluding non financial assets	11,340	**11,340**
Cash and cash equivalents at bank and in hand	30,165	**30,165**
Total at 31 March 2018	**41,505**	**41,505**

	Loans and receivables	Total book value
	£000	£000
Assets as per SoFP as at 31 March 2017		
Trade and other receivables excluding non financial assets	4,802	**4,802**
Cash and cash equivalents at bank and in hand	19,085	**19,085**
Total at 31 March 2017	**23,887**	**23,887**

Values for 2016-17 have been updated to include £2,033 accrued and other income

Note 27.3 Carrying value of financial liabilities

	Other financial liabilities	Total book value
	£000	£000
Liabilities as per SoFP as at 31 March 2018		
Borrowings excluding finance lease and PFI liabilities	4,835	**4,835**
Trade and other payables excluding non financial liabilities	18,705	**18,705**
Provisions under contract	4,669	**4,669**
Total at 31 March 2018	**28,209**	**28,209**

	Other financial liabilities	Total book value
	£000	£000
Liabilities as per SoFP as at 31 March 2017		
Borrowings excluding finance lease and PFI liabilities	6,636	**6,636**
Trade and other payables excluding non financial liabilities	13,448	**13,448**
Provisions under contract	2,141	**2,141**
Total at 31 March 2017	**22,225**	**22,225**

Note 27.4 Fair values of financial assets and liabilities

In all cases, book value (carrying value) is a reasonable approximation of fair value.

Values for 2016-17 have been updated to include £7,185 accruals and £2,141 provisions under contract

Note 27.5 Maturity of financial liabilities

	31 March 2018	31 March 2017
	£000	£000
In one year or less	23,708	16,246
In more than one year but not more than two years	334	823
In more than two years but not more than five years	1,002	1,657
In more than five years	3,165	3,499
Total	**28,209**	**22,225**

Note 28 Losses and special payments

	2017/18		2016/17	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	13	14	-	-
Fruitless payments	-	-	2	0
Bad debts and claims abandoned	30	56	13	2
Stores losses and damage to property	8	5	12	3
Total losses	**51**	**75**	**27**	**6**
Special payments				
Compensation under court order or legally binding arbitration award	1	-	1	0
Extra-contractual payments	-	-	-	-
Ex-gratia payments	82	433	88	520
Special severence payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**83**	**433**	**89**	**520**
Total losses and special payments	**134**	**508**	**116**	**525**
Compensation payments received		-		-

There were no individual losses or special payments amounting to more than £300,000

Note 29 Related parties

The Department of Health and Social Care is regarded as a related party. During the year Yorkshire Ambulance Service NHS Trust has had a significant number of material transactions with the Department (defined as constituting over 1% of turnover), and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

NHS Sheffield CCG
NHS Wakefield CCG
NHS Bradford Districts CCG
NHS Leeds South and East CCG
NHS Vale of York CCG
NHS East Riding of Yorkshire CCG
NHS Leeds West CCG
NHS Greater Huddersfield CCG
NHS Calderdale CCG
NHS Doncaster CCG
NHS Hull CCG
NHS Leeds North CCG
NHS Barnsley CCG
NHS Rotherham CCG
NHS North Kirklees CCG
NHS Hambleton, Richmondshire and Whitby CCG
NHS Airedale, Wharfdale and Craven CCG
NHS Harrogate and Rural District CCG
NHS Scarborough and Ryedale CCG
NHS Bradford City CCG
NHS England
NHS Pension Scheme
HM Revenue & Customs

This note discloses related parties where income or expenditure is more than 1% of our operating income or expenditure, or that are material by nature (the YAS Charitable Fund). Other than the Charitable Fund transactions below this level are not considered material for the purposes of this disclosure.

Except as detailed below no Trust board members had any interest in any of these organisations during the financial year. No Trust board member has declared an interest in any other organisation with which the Trust does business.
The Trust works with the Yorkshire Air Ambulance charity and provides clinical staff for that service. Dr David Macklin works as Medical Director for that charity.
The Trust Board is the Corporate Trustee of the Yorkshire Ambulance Service NHS Charitable Trust Charity No. 1114106. Transactions between the Charity and the Trust during the year were not material.

Note 30 Events after the reporting date

There have been non non-adjusting events after the reporting period.

Note 31 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	23,877	103,909	30,869	86,721
Total non-NHS trade invoices paid within target	20,326	96,949	27,141	76,456
Percentage of non-NHS trade invoices paid within target	85.1%	93.3%	87.9%	88.2%
NHS Payables				
Total NHS trade invoices paid in the year	527	3,048	551	3,292
Total NHS trade invoices paid within target	415	2,444	447	2,806
Percentage of NHS trade invoices paid within target	78.7%	80.2%	81.1%	85.2%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 32 External financing

The trust is given an external financing limit against which it is permitted to underspend:

	2017/18 £000	2016/17 £000
Cash flow financing	(12,750)	1,657
External financing requirement	(12,750)	1,657
External financing limit (EFL)	(4,448)	2,042
Under / (over) spend against EFL	8,302	385

Note 33 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	7,561	12,675
Less: Disposals	(190)	(774)
Less: Donated and granted capital additions	-	-
Plus: Loss on disposal of donated/granted assets	-	-
Charge against Capital Resource Limit	7,371	11,901
Capital Resource Limit	8,664	12,126
Under / (over) spend against CRL	1,293	225

Note 34 Breakeven duty financial performance

	2017/18 £000
Adjusted financial performance surplus (control total basis)	9,304
CQUIN reserve adjustment	850
Breakeven duty financial performance surplus / (deficit)	10,154

Note 35 Breakeven duty rolling assessment

	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	2017/18 £000
Breakeven duty in-year financial performance		518	237	428	2,223	2,633	2,991	6,103	2,719	10,154
Breakeven duty cumulative position	3,501	4,019	4,256	4,684	6,907	9,540	12,531	18,634	21,353	31,507
Operating income		197,910	195,228	200,333	209,772	233,384	241,328	248,965	255,424	269,451
Cumulative breakeven position as a percentage of operating income		2.03%	2.18%	2.34%	3.29%	4.09%	5.19%	7.48%	8.36%	11.69%

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 has helped to inform changes in national performance standards for all ambulance services.
Ambulance Service Cardiovascular Quality Initiative	The initiative aims to improve the delivery of pre-hospital (ambulance service) care for cardiovascular disease to improve services for people with heart attack and stroke.
Annual Assurance Statement	The means by which the Accountable Officer declares his or her approach to, and responsibility for, risk management, internal control and corporate governance. It is also the vehicle for highlighting weaknesses which exist in the internal control system within the organisation. It forms part of the Annual Report and Accounts.
Automated External Defibrillator (AED)	A portable device that delivers an electric shock through the chest to the heart. The shock can then stop an irregular rhythm and allow a normal rhythm to resume in a heart in sudden cardiac arrest.
Bare Below the Elbows	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.
Chairman	The Chairman 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 Commissioning Group (CCG)	Groups of clinicians who commission healthcare services for their communities. They replaced primary care trusts (PCTs).
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.
Clinical Supervisor	Works on the frontline as part of the operational management team and facilitates the development of clinical staff and helps them to practise safely and

	effectively by carrying out regular assessment and revalidations.
Commissioners	Ensure that services they fund can meet the needs of patients.
Community First Responders (CFRs)	Volunteers in their local communities, who respond from their home addresses or places of work to patients suffering life-threatening emergencies.
Comprehensive Local Research Networks (CLRNs)	Coordinate and facilitate the conduct of clinical research and provide a wide range of support to the local research community.
Computer Aided Dispatch (CAD)	A method of dispatching ambulance resources.
Commissioning for Quality and Innovation (CQUIN)	The Commissioning for Quality and Innovation (CQUIN) payment framework enables commissioners to reward excellence by linking a proportion of providers' income to the achievement of local quality improvement goals.
Dashboards	Summary of progress against Key Performance Indicators for review by managers or committees.
Dataset	A collection of data, usually presented in tabular form.
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.
Emergency Care Assistant (ECA)	Emergency Care Assistants work with clinicians responding to emergency calls. They work alongside a more qualified member of the ambulance team, giving support and help to enable them to provide patients with potentially life-saving care at the scene and transporting patients to hospital.
Emergency Care Practitioner (ECP)	Emergency Care Practitioners are paramedics who have received additional training in physical assessment, minor illnesses, minor injuries, working with the elderly, paediatric assessment, mental health and pharmacology.
Emergency Department (ED)	A hospital department responsible for assessing and treating patients with serious injuries or illnesses.
Emergency Medical Technician (EMT)	Works on an emergency ambulance to provide the care, treatment and safe transport of patients.
Emergency Operations	The department which handles all our emergency and

Centre (EOC)	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.
Foundation Trust Development Group	This is made up of the YAS Chairman and YAS Trust Executives.
General Practitioner (GP)	A doctor who is based in the community and manages all aspects of family health.
Governance	The systems and processes, by which health bodies lead, direct and control their functions, in order to achieve organisational objectives, and by which they relate to their partners and wider community.
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 new independent consumer champion for health and social care in England. Local Healthwatch organisations have also been set up. Local Healthwatch organisations are a network of individuals and community groups, such as faith groups and residents' associations, working together to improve health and social care services. Healthwatch organisations started to replace LINks (Local Involvement Networks) from October 2012.
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	The directorate responsible for the development and maintenance of all ICT systems and processes across

Technology (ICT)	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.
KA34	A reporting requirement for all ambulance trusts, with a template completed annually and submitted to the Department of Health. The information obtained from the KA34 is analysed by individual ambulance service providers to show volume of service and performance against required standards.
Key Performance Indicator (KPI)	A measure of performance.
Knowledge and Skills Framework (KSF)	A competence framework to support personal development and career progression within the NHS.
Major Trauma	Major trauma is serious injury and generally includes such injuries as: ▪ traumatic injury requiring amputation of a limb ▪ severe knife and gunshot wounds ▪ major head injury ▪ multiple injuries to different parts of the body eg chest and abdominal injury with a fractured pelvis ▪ spinal injury ▪ severe burns.
Major Trauma Centre	A network of centres throughout the UK, specialising in treating patients who suffer from major trauma.
Mental Capacity Act (MCA)	Legislation designed to protect people who can't make decisions for themselves or lack the mental capacity to do so.
Myocardial Infarction (MI)	Commonly known as a heart attack, an MI is the interruption of blood supply to part of the heart, causing heart cells to die.
National 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	Provides NHS staff with access to a wide range of national and local NHS eLearning courses as well as

(NLMS)	access to an individual's full training history.
National Reporting and Learning System (NRLS)	The NRLS is managed by NHS Improvement. The system enables patient safety incident reports to be submitted to a national database. This data is then analysed to identify hazards, risks and opportunities to improve the safety of patient care.
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.
NHS England	NHS England is responsible for Clinical Commissioning Groups (CCGs), working collaboratively with partners and encouraging patient and public participation in the NHS.
NHS Improvement	NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care.
Non-Executive Directors (NEDs)	Drawn from the local community served by the Trust, they oversee the delivery of ambulance services and help ensure the best use of financial resources to maximise benefits for patients. They also contribute to plans to improve and develop services which meet the area's particular needs.
Paramedic	Senior ambulance service healthcare professionals at an accident or medical emergency. Working alone or with colleagues, they assess a patient's condition and provide essential treatment.
Paramedic Practitioner	Paramedic practitioners come from a paramedic background and have additional training in injury assessment and diagnostic abilities.
Patient Report Form (PRF)	A comprehensive record of the care provided to patients.
Patient Transport Service (PTS)	A non-emergency medical transport service, for example, to and from out-patient appointments.
Personal Development Reviews (PDRs)	The PDR process provides a framework for identifying staff development and training needs and agreeing objectives.
Personal Digital Assistants (PDAs)	Small computer units which help to capture more accurate data on Patient Transport Service performance and journey times and identify areas which require improvements.
Private and Events Service	Provides medical cover to private and social events for example, football matches, race meetings, concerts and festivals. It also provides ambulance transport for private hospitals, corporations and individuals.
Quality Governance Framework	A process to ensure that YAS is able to monitor and progress quality indicators from both internal and external sources.
Quality Strategy	Framework for the management of quality within

	Yorkshire Ambulance Service.
Rapid Response Vehicle (RRV)	A car operated by the ambulance service to respond to medical emergencies either in addition to, or in place of, an ambulance capable of transporting patients.
Red 1 and 2 Calls	Previously an immediate life-threatening situation requiring emergency assistance eg cardiac arrest, choking, uncontrolled haemorrhage etc. The objective is to provide immediate aid to apply life-saving skills supported by paramedic intervention.
Resilience	The ability of a system or organisation to recover from a catastrophic failure.
Return of Spontaneous Circulation (ROSC)	ROSC is resumption of sustained perfusing cardiac activity associated with significant respiratory effort after cardiac arrest.
Safeguarding	Processes and systems for the protection of vulnerable adults, children and young people.
Safeguarding Referral	Yorkshire Ambulance Service staff are given information to help them identify warning signs of abuse or neglect and to report this via our Clinical Hub, to social care. Social care will follow up each referral to ensure that the vulnerable adult or child involved is safe.
Safety Thermometer	The NHS Safety Thermometer is a tool designed to help hospitals understand where they can potentially cause harm to patients and reduce the risk of this.
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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