North East Ambulance Service NHS
NHS Trust

North East Ambulance Service

Annual report 2009/2010

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Chairman's introduction

It gives me great pleasure to introduce our annual report, for the seventh time. As I look back over the years of my chairmanship, I take a lot of pride in the improvements we have made to our services, as we show in this report. We can say honestly that we provide high-quality services (whether speaking to customers on the phone, in our contact centres, in our ambulances when we assess patients, provide necessary treatment and take them to hospital or in our training and activities to prepare for emergencies, which the public are often not aware of).

Since last year's annual report, we have focused on monitoring the quality of our services to make sure we continue to provide high standards of care as we prepare for foundation trust status. By becoming a foundation trust, people would have more of a say on the decisions we make within the ambulance service. We would also have more funding. To help with this, I reorganised the board to make sure that we had the right mix of experience and skills so that we would be fit for the future – not only as a foundation trust but also because of the current demanding financial environment. As a result, I am pleased to welcome five new colleagues. On the executive team, Ann Fox, a qualified nurse, has joined us as Director of Clinical Care and Patient Safety, working alongside Mr Kyee Han, a consultant in emergency medicine, as Medical Director. On the non-executive side, I welcome Chris Suddes, Wendy Lawson and Jeff Fitzpatrick, who bring to the board considerable skills in areas such as arranging transport, managing call centres and commercial insight.

We have been very busy preparing for our foundation status. We held a three-month public consultation during the summer of 2009 and received comments on our plans from a wide range of people and organisations who were interested in the ambulance service. During this time, over 4200 people became members of the trust – far more than we had originally hoped. As I write this, we have well over 7000 members and are working hard to keep them updated on our plans for the future. We want our members, and future governors when we appoint them, to help us deliver services that people in the North East need and want, whatever their race, religion, age, disability, sexuality or sex.

Providing equal opportunities is very important to us, both in the services we deliver and the way we employ people. I am proud to report that we achieved 70th place in Stonewall's workplace equality index and we are an 'Equality and diversity partner with NHS employers' for 2010/2011. These are very significant achievements and demonstrate our strong commitment to achieving a fair society.

We reviewed our business plan and long-term financial plan this year. We are very keen to involve staff and stakeholders (people with an interest in our organisation) in developing our main aims for the future. These aims are to:

- set a good example to other ambulance services in the way we provide emergency care;
- help to make significant changes in the way urgent and emergency care is provided in the North East;
- improve patient transport services;
- be an outstanding employer;
- be successful financially; and
- be well-organised and responsible for everything we do.

We want to achieve these aims by:

- being committed, professional and responsible;
- working well as a trust;
- always delivering a high-quality service;
- shaping the future; and
- showing we care.

I am grateful to all my colleagues on the board for their support and hard work during the last year. I would like to thank all our staff and stakeholders who have done so much to improve the lives of our patients – your dedication to the job in hand always inspires me.

Chief Executive's end of year statement

In 2009/10 we worked very hard to successfully improve our services, as I will go on to explain.

Despite the swine-flu pandemic and the coldest winter for many years, we met our target to respond to 75% of life-threatening calls within eight minutes. This achievement was a real team effort by our directorates at the trust and our commissioners across the North East.

After almost three years of consultation and planning, we finally opened our new contact centre in South Tyneside. This is a state-of-the-art facility that has really improved how well our ambulance service can respond to the 2.65 million people who live in the North East. The centre is named Russell House, in memory of an estates adviser who was much respected and worked for us for a long time. The building also houses a new ambulance station for the Hebburn area, our emergency planning department and our new hazardous area response team (HART).

After setting up the 'NHS pathways' and 'capacity management' systems a few years ago, we have continued to lead the way on a new and consistent approach to assessing patients' needs over the phone and referring them to the correct service. This approach has been well-researched and offers value for money. I am pleased to report that in October 2009, in partnership with County Durham's NHS services, we successfully set up a phoneline that people could ring if they weren't sure who to call about their health problem. As well as this, we are about to develop a new urgent-care three-digit number ('111'), which people can use as an alternative to '999'. For example, if a patient is not sure whether their symptoms are serious enough to phone 999, they can get advice from one of the operators. If this is successful, '111' will be used across the UK.

As we move closer to foundation trust status, we will need to take a more business-like approach to how we arrange the funding and monitoring of NHS services. For example, we have been working with our commissioning partners and other primary care trusts (PCTs) to develop a new model of funding for our ambulances. We will try out this system next year to see whether it gives patients the best results in terms of quality of care. Again, the results are influencing national policy on 'payment-by-results' for ambulance services.

We are confident we can build upon the hard-earned improvements we have made over the last few years and can continue to give the taxpayer the best possible value for money for our services. I am pleased to report that we are well on our way to doing this. Last year, the costs of running our emergency ambulance services were 83% of what the average English ambulance services spent – the lowest in the country. This is a trend which we expect to continue this year.

We firmly believe that working in partnerships to improve the whole system of health and social care is vital if we want to have patient care and transport services that meet the demands of today's society.

There are many other achievements and initiatives which I could mention here, but I will leave those for you to discover in the pages that follow. The needs of patients are what motivate our people and determine the shape of our services. I hope that you enjoy reading our annual report and will continue to share a sense of pride in what we have achieved for you.

Ambulance operations

We cover an area of some 3230 square miles and provide emergency care to around 2.65 million people.

Our operations directorate covers:

- accident and emergency;
- patient transport services;
- emergency planning and resilience;
- the hazardous area response team (HART); and operational support (this includes our vehicles, equipment, ambulance resource assistants and resource scheduling

Accident and emergency

The accident and emergency (A&E) service provides emergency and urgent care to patients. Members of the public contact the service by phoning '999' and asking for an ambulance. Doctors can also use the service by referring their patients to A&E.

We also provide a service to the hospitals in our region where we transport patients to facilities so they can receive specialised care. This may sometimes mean we have to take them to hospitals outside of the area our trust covers.

How accident and emergency have performed in the last year

Once again this year, we have beaten the Government's target of responding to 75% of all 'category A' calls (where somebody's life is threatened) within eight minutes. In 2009-2010, we responded to 75.45% of calls within eight minutes.

In 2009-2010, our A&E crews dealt with 103,757 emergency incidents, which was an increase of 14.25% on 2008-2009. This meant crews dealt with about 8646 incidents every month.

Unfortunately, we fell just below the Government's target for responding to 'category B' calls (where somebody was seriously ill or injured but their life was not threatened) within 19 minutes. We responded to 93.97% of calls within 19 minutes. We responded to 148,562 of these calls in 2009-2010, which is the same as about 12,380 every month. The very bad weather made it very difficult for our crews to respond in time.

Our control-room staff, front-line operational ambulance crews, voluntary staff (such as St John Ambulance and Red Cross), First Responders (medically trained volunteers), mountain rescue and other support staff have worked incredibly hard to meet these standards and have shown great skill, dedication and knowledge in doing so.

During last year's particularly bad weather, all of these agencies worked well together to provide a great service to people living in the north east of England.

We try our best to treat patients where they have called an ambulance from, without taking them to hospital (we call this 'see and treat'). In the last few years, we have treated 30,000 more people at home rather than at hospital. This benefits patients who have a minor injury or an illness that isn't life-threatening. They can be treated at home and don't have to travel to and wait at an A&E unit, where more serious cases are given priority. This also benefits the hospitals in our region and us in how we manage the care we give our patients.

In the past year, we have done the following to improve the quality of the care we provide.

- Increased the number of community paramedics in rural areas.
- Developed and improved our links with the falls teams (who focus on groups of people, such as elderly people, who are at risk from being injured after falling) throughout the North East. We are pleased that, through working with a number of organisations, we have successfully reduced the number of falls in people over 60. We have received significant national recognition for this work and we have spoken at conferences to encourage other trusts to follow our example.
- Worked closely with voluntary agencies (such as St John Ambulance and Red Cross) over Christmas and the new year to make sure we can treat everybody who needs medical care.
- Worked closely with acute trusts, such as hospitals, to improve health-care services, for example, by setting up a rural ambulance service and 'Seizing the future' (a programme that aims to develop the way we work for the next five years).

Patient transport service

The patient transport service (PTS) is an important and essential part of the ambulance service. The PTS transport around 2700 non-emergency patients each day, including transporting patients to outpatient departments, rehabilitation centres, day-surgery units and to other health-related appointments.

During 2009/10, the patient transport service made 1,147,279 journeys. This was made possible through the modern software in our control and planning sections. Patients were transported across the north of England, often travelling from southern Scotland, as far west as Whitehaven and to Whitby and Leeds to the south. We can transport anybody, even if they need a stretcher or a wheelchair. Despite the large number of patients, most of them arrived at their appointments or left their homes within the time limits we aimed to keep to. To improve this service, we will try to take more people to their appointments at short notice (for example, if we are told on the day of the appointment that somebody needs transport).

Once again, the PTS would not have had this success without the commitment, hard work and dedication of the staff in our planning department and control department, and our operational and support staff. These people help us to maintain the high standards that we have achieved over recent years.

Following on from last year's in-depth review of the PTS, we are now well on our way to setting up the project to improve PTS . We have already set up its management team and we now want to try to make people aware of how non-emergency transport services work and how they provide a valuable service to the community. We are working hard to develop the PTS service in line with patients' needs.

The PTS are now responsible for our customer care team. The customer care team work with GPs, social services and the police in local areas to identify vulnerable people who often have health problems and who tend to phone 999 when they do not have an emergency. The team work with these people to deal with any problems they may have and try to reduce the number of non-emergency calls.

The customer care team have continued to work with falls teams across the service area. This has meant many more elderly and vulnerable people are getting appropriate help when they need it.

In the past year, we have set up the following.

- Bariatric vehicles – these vehicles are specially designed to transport and help with moving and handling patients who weigh over 25 stone. We have two of these vehicles and they are available 24 hours a day, seven days a week.

- Vehicle tracking – most PTS vehicles are now fitted with equipment so our control centre knows exactly where they are. We use vehicle tracking to help us respond to some emergency calls. This also means our control-centre staff can keep details of when an ambulance arrives at the scene of an emergency and when they arrive at hospital (if this applies). We hope that this new technology will make our emergency services quicker and more flexible.

- New contracts – last year, NHS County Durham and Darlington PCT asked us to provide urgent-care transport on their behalf. This is going well.

Emergency planning and resilience

Our emergency planning and resilience department have continued to improve our service by making sure our staff, including paramedics and managers, are appropriately trained and prepared to respond effectively to difficult, significant or major incidents, such as chemical spills or terrorist attacks. They have done this by arranging a three-day advanced 'major-incident medical management and support' (MIMMS) course. On this course, on-call officers have the opportunity to use and add to their emergency care skills. We also run a one-day MIMMS course for operational staff, who include paramedics and other medically trained staff. The aim of this course is to refresh their skills so they can manage an emergency situation before paramedics arrive. We also run other courses that encourage our staff to move forward in their careers. These courses include media training, decision-making, safety at stadiums and sports grounds and both the gold and silver 'chemical, biological, radiological and nuclear command' (CBRN) courses.

We created a pandemic influenza plan in 2009. We have now reviewed it and will be updating it throughout the year in line with national guidelines and aims. We review our major-incident plan regularly, after carrying out a number of planned exercises throughout the region and after agreeing any changes to the plan at board meetings.

We are preparing for the 2012 Olympics. The North East has a large number of training camps that athletes may be able to use in the build-up to the Olympics. We will work with other agencies to make sure these athletes are safe while they are in the North East. St James' Park will host one of the football groups. If we are fortunate in having a popular team within the group, this could improve the reputation of St James' Park as an excellent sports venue.

Our emergency planning department have continued to work with stakeholders and partner agencies to make sure appropriate plans are in place to respond to any emergency, such as a terrorist attack.

We have developed business continuity and disaster recovery plans to make sure we are still able to function if there is an emergency. We practise these plans every year.

Hazardous area response teams (HART)

The Government recently asked ambulance services around the country to set up hazardous area response teams (HART). HART help people who are in dangerous situations, for example, in collapsed buildings. They work closely with the fire and rescue services.

We have also set up specialist teams - the HART incident response unit (HART-IRU) and an urban search and rescue (HART-USAR) unit. We hope that HART will make it easier for us to improve how we meet our patients' needs.

We set up HART on 22 March 2010.

Operational support

The operational support department are in charge of our vehicles, equipment, ambulance resource assistants and resource scheduling (for example, arranging annual leave and cover for staff who are on annual leave).

We have around 459 vehicles including ambulances (used by paramedics to take patients to A&E), non-emergency vehicles (used by the PTS), rapid response vehicles (ambulance cars) and emergency-planning vehicles, which include specialist equipment needed in an emergency.

We replace our vehicles every seven years. We buy them or we lease them. All vehicles are supplied to us with all of the equipment we need to use the vehicles to treat patients and carry them safely to A&E.

We maintain our vehicles regularly, based on the Vehicle Operator Service Agency's (VOSA) guidelines and the vehicle manufacturer's recommended service schedules. Our fleet maintenance team maintain all equipment onboard the vehicles at the same time as the vehicles themselves. When they do this, they keep to the Medicines and Healthcare Regulatory Agency's (MHRA) requirements and the equipment manufacturer's standards.

Our fleet maintenance team are made up of 33 staff, who carry out over 3500 routine inspections every year. As part of the maintenance schedule, the team make sure equipment is programmed properly and is in good working order. They also make sure vehicles are always ready for paramedics to use. This reduces the amount of time the paramedics take to check vehicles, so they are free to care for patients.

Our ambulance resource assistants (ARAs) make over 9000 journeys each year. It is their job to make sure that the right vehicles are in the right locations throughout the area that we cover. ARAs also keep and monitor back-up vehicles in various places around the North East in case a vehicle breaks down or there is an accident.

We clean our vehicles and equipment regularly. We wipe down equipment throughout the day and we give them a thorough clean every day. The way we clean stretchers, trolleys and other large equipment is similar to the way beds are cleaned in hospitals. We place the items inside a unit, similar to a huge dishwasher, and they are cleaned with detergents that get rid of MRSA and Clostridium difficile (C difficile). We are currently the only ambulance service in the UK that cleans equipment in this way.

In the past year, we have done the following to improve our vehicles and the way we use them.

- After the Freight Transport Association (FTA) reviewed our vehicles and how we used them last year, we are working through their recommendations and looking at how we can improve.

- We are still involved in the National Strategic Ambulance Fleet Group which is a part of the Chief Executive's group. (Our Director of Operations and our Operational Support Manager chair the National Strategic Fleet Group.)

Staff are now able to access their schedules and information from the resource scheduling department (RSD) from their home. This means the communication between staff who are at home (for example, on leave or not at work) and in the office has improved greatly.

The RSD have upgraded their system to the GRS (global rostering system) which works more efficiently, including better managing of overtime. The department will also upgrade to the Symposium call system in the near future, which means they will be able to deal with enquiries more effectively and efficiently.

In the coming months, the department are planning to continue scheduling shifts so that we have plenty of staff available when we need them.

Foundation Trust

Foundation trusts are still a part of the NHS, but they are modelled on organisations which benefit the public and their members are made up of the communities they serve. Members elect a council of governors, which also includes representatives from primary care trusts, local authorities, universities and other organisations. The council of governors will work with the board of directors to make sure we work effectively and continue to improve year after year.

Foundation trust consultation

Between 5 June and 28 August 2009, we carried out a large consultation, where we asked the public and our staff what they thought about our plans to become a foundation trust.

We sent out nearly 4000 full consultation documents and 20,000 summary consultation documents across the area our trust covers. These documents gave background information about the ambulance service and details of our proposals. As well as this, we held many public meetings and focus groups across the North East. We also phoned 1000 people to ask what they thought about the proposals.

Over 1000 people attended a presentation on our proposals and we received more than 1150 responses to our plans to become a foundation trust.

Most of the responses supported or did not have an opinion on our plans, but these responses included suggested changes. For instance, to raise the number of governors in our PCT. As a result of the consultation, we made several changes to our plans. We had suggested the minimum age for being a member of our council should be 12 years old. However, a lot of people felt that 12-year-olds were too young to take part. While we felt it was important to include young people in our decisions and to give them a say, we agreed to raise the minimum age to 16 years.

People also told us that there should be more people from local authorities on our council. As a result, we now have three local government governors on our council, representing a rural council, a town council and a city council.

Foundation trust membership – involvement with our public & patients

Becoming a foundation trust will mean that the services we provide will be owned by local people and our employees. We will also have to answer to them. Because of this, we will work more closely with the communities we serve and involve them in what we do.

We already try to involve people who use our services and carers in how we deliver and develop our services. We work closely with local involvement networks, patient groups and community representatives and will continue to do so as a foundation trust. We will also continue to use the feedback we receive through local and national patient surveys and local authority health overview and scrutiny committees.

Being a member of our foundation trust does not change the way people are treated, or give any benefits, but members will:

- have a say in our decision-making process and influence how we develop as a trust;
- receive regular information on our activities and how well we are doing;
- be consulted on major plans for developments we make and services we want to introduce;
- be able to vote in elections to the council of governors; and
- have the right to stand for election to the council of governors.

We agreed a membership strategy in 2009/10 to guide how we recruit foundation trust members. This strategy began at the same time as the public consultation. By 31 March 2010, 7202 members of the public had asked to become foundation trust members. We have started a programme to involve them in our work.

All new members receive a welcome letter with a membership card showing their membership number. On 15 January 2010 we sent out our first newsletter, called 'Your Call', to 7155 members of the public who are trust members. (We will send members a newsletter every three months.) We have also organised several meetings for members who have told us they are interested in becoming a governor. We set up a number of events to encourage our members to think about health issues, such as a health awareness day we organised with the help of Northumberland Tyne and Wear NHS Trust and a 'Medicine for members' event with South Tyneside hospitals on 'What happens when you dial 999 with chest pains'. We hope to hold many of these events in the coming years.

Anyone interested in becoming a member of our foundation trust can join online at www.nhs-membership.co.uk/neas or contact our Membership Officer, Susan Coldron, on 0191 430 2263.

Community involvement

Sometimes, people who use our services don't feel they have a strong-enough voice to change their health. We began working with the new local involvement networks (LINks) in 2008 to help the community to have a say on the health care available to them.

LINks aim to give local residents a stronger voice in how their health services are delivered. Run by local individuals and groups, the role of LINks is to find out what people want, monitor local services, and use people's views to influence those services. There is a LINk in each of the 12 local authority areas in the north east of England. The LINks have formed a group with us to make sure that members of the public are involved in how we run our ambulance service and tell us if they think there is something we could improve on. This group is known as the Ambulance LINk Forum.

To develop the LINks' awareness of ambulance health issues, members attended meetings every other month throughout 2009/10 and were able to visit and look around our headquarters at Bernicia House, Pallion ambulance station and vehicle workshops in Sunderland. We also invited them to the opening ceremony of our second contact centre and emergency planning unit at Russell House.

LINk members usually arrange their own funding. However, where they can't do this, we will meet their reasonable expenses. We have developed a policy to make sure that costs do not stop LINk members from becoming involved. This policy came into effect in July 2009.

Throughout the year, the Ambulance LINk Forum have been involved in a number of projects. For example, the forum played an important part in our consultation into our application to become a foundation trust and managed our consultation process. They then helped go through all the responses we received and gave them to our board.

The LINk forum also played a big part in helping us to develop our 'Vision, values and mission statement' in 2009/10. We considered the comments they made and we put many of their suggestions in the final copy.

We have also given presentations to the forum on how to prevent and control infection, how to deal with complaints, and on our first published Quality Account. The forum have asked us about how we respond to emergencies in rural areas, how we deal with requests from patients who need transport to hospital appointments and the effect of hospital configurations in County Durham under the 'Seizing the future' initiative.

We are really looking forward to continuing to work with LINks over the coming years.

We have also continued to work closely with the overview and scrutiny committees in the region and were pleased to help take part in a pilot scheme to create a health scrutiny committee in the North East, which we hope to set up in late 2010. NHS trusts must answer to local authority overview and scrutiny committees for the services they provide. We are grateful for the time and effort that these organisations take to listen to us and give us their feedback on the work we do.

Finally, we have had another busy year visiting schools, clubs, fêtes, organisations, events and career roadshows across the region. In doing this, we hope we have helped to educate the public about how to prevent accidents, the work that emergency services do and what it is like to work for us. Some of these events, such as the 'Reduction of accident at play' initiative in South Tyneside, involved the education of thousands of children.

We organise a large number of events on how to prevent children from being injured through accidents. People are never too young to learn how to avoid accidents and what to do if there is an accident. We hold safety workshops regularly and they are staffed by paramedics and control-room and patient transport service staff. The aim is to teach children from as young as three years old what they can do if there is an emergency.

Other schemes we are involved in include the Sure Start Baby programme, where our paramedics give advice to parents on dealing with choking, and what to do if a baby has a heart attack. We have also worked closely with Cleveland Fire Brigade on talking to teenagers about road safety. This scheme involved well over 4000 people.

Our customer care team have helped to promote the support that is available for people who are at risk of falls because they are elderly or disabled, and need our help and the help of social care teams. The team have arranged events where people within our community can familiarise themselves with ambulance equipment and staff. We do this in the hope that if people need to travel by ambulance themselves, the experience will be less traumatising.

Complaints and letters of appreciation

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Complaints

We take seriously all complaints, concerns and comments we receive. We take appropriate action if a service has not been provided at the standard we expect. We have a complaints procedure that is in line with NHS complaints regulations.

If we receive a complaint, we will do the following.

- Within three working days of receiving your complaint, tell you we have received your complaint. We will do this either by phoning or writing to you.
- Within 25 working days, or longer if you agree, write to you to tell you what we are doing about your complaint. We will usually ask our Chief Executive to send you a final response to your complaint.

From 1 April 2009 to 31 March 2010, we received a total of 198 complaints from people who wanted a written reply from the Chief Executive. Of these complaints, four were not progressed as the appropriate patient consent was not received. We sorted out 36 complaints after discussing the problem with our Investigating Officer. We investigated the rest of the complaints and the outcomes of these investigations were as follows.

- 90 complaints were upheld.
- 49 complaints were not upheld.
- 19 complaints are still under investigation at the time of writing this report.

What we receive complaints about and how we deal with them

The complaints we received from 1 April 2009 to 31 March 2010 were about the following.

- Accident and emergency service
- Staff attitude
- The quality of care that has been provided
- Outcome of the triage (the initial assessment in the call centre) of a 999 emergency call
- Time waiting for an ambulance to arrive

We received the following complaints about the patient transport service.

- Some vehicles were late for appointments
- Patients had to wait for transport after their appointments had finished
- Some patients were not taken to their appointments
- Staff attitude

It is important that we learn from complaints and improve the service we provide after we have investigated them. Most improvements will only benefit the person involved in the complaint. There are, however, some improvements we need to make as a result of complaints that affect the way we do things. If this happens, we will change for the better.

So that we can share what we have learnt after investigating complaints with staff, we send out a clinical practice circular to staff. We wrote about some of the following issues in our last circular.

Summertime sports and their risks
The Joint Royal Colleges Ambulance Liaison Committee JRCALC guidelines often refer to head injuries caused by road accidents and weapons, but in the summer, bats and balls can also be dangerous. For example, if a swinging bat hits somebody on the head, it can cause skull fractures and even bleeding on the brain. Because of this, patients should be examined carefully and if they are found to have these injuries, they should be sent to A&E. Though the 'Talk and Die' syndrome is rare, taking a patient to A&E could save their life.

End Of Life care plans
Recently, our ambulance staff have had difficulties with patients who have collapsed but who do not want to receive medical care. We have also had problems with ambulance staff not being sure whether patients wanted to be resuscitated. As a result, we have given ambulance staff new guidelines.

We recognise that this can be a very difficult and demanding area of patient care, and we continue to work alongside key stakeholders and professional colleagues from across the NHS in the North East to develop a system to provide care for all patients who are reaching the end of their life and their families.

We recently gave staff new guidelines on how to record Morphine administration following an incident.

As well as sending out clinical practice circulars, we:

- carried out an audit across the trust (this finished in March 2010);
- changed our policy on controlled drugs to include clear guidance on how to record the doses that are given;
- made a podcast available to help to train staff; and
- changed our training plans to include the new guidance.

Changes we made to the way we work after we received complaints
We made changes to our patient transport service (PTS) after a vehicle was late in collecting a patient. This happened because the equipment that sends information about appointments from our control centre to our vehicles couldn't do so because the vehicle's equipment had no signal. As a result, we have changed the system so that staff in our control centre will be alerted when a signal has been lost.

After we received a 999 call about somebody who had been burnt, the call-centre staff member answering the call did not give the caller care advice. This was because they had chosen to deviate from the advice given by the system. The member of staff should have given this information to the caller. We made changes to the system to make sure callers receive advice on the care they should give to the injured person. We also added to our 'Major Burn' pathway to help staff when dealing with a call.

The Parliamentary and Health Service Ombudsman (PHSO)

If you complain to us and you are not happy with how we have tried to sort out any, you can ask the PHSO to review the complaint.

(The Healthcare Commission used to deal with these 'second-stage' complaints until new regulations were introduced on 1 April 2009.)

At the time of this report, the PHSO were asked to review four complaints received in 2008/09. Of these, the PHSO worked with us to sort out one complaint. They decided not to uphold the remaining three complaints.

So far for the year 2009/10, one complaint has been referred to the ombudsman. They have decided not to uphold the complaint. We will continue to work with the PHSO to sort out any problems and improve our services.

Patient involvement and complaints committee (PICC)

The patient involvement and complaints committee (a committee of our board) meet every three months. The PICC:

- review all complaints to check we are keeping to national guidelines;
- identify any mistakes we have made;
- look at whether mistakes we have made are related; and
- make sure we take action to improve the way we work as a result of complaints we have received.

The PICC are responsible for overseeing how we monitor the experiences our patients have of our services and how we involve patients in how we run our services.

Letters of appreciation

We received 265 letters of appreciation during 2008/09. Of these, 246 were to from patients or their families to thank us for the care they had received. We think it is important to share these letters with the staff who have been involved in providing the care that the patient has been so pleased with.

Workforce

Our staff, our future

Throughout 2009/10, we have continued to put in place our human resources and organisational development strategy, which supports our business plan.

Putting into place the workforce development plan

During 2009/10, we made good progress in putting our workforce plan into action. A total of 210 new staff joined us in a range of roles, including student paramedics, emergency care support workers and ambulance care assistants. We also employed extra staff to cope with both the swine flu pandemic and the increase in illnesses over the winter.

During 2009, we started planning for our new hazardous area response team, which has now been set up. The work the team does is funded by the Department of Health. We employ 42 staff on this team, who are based at Russell House in Monkton.

We have been successful in our bid to run the out-of-hours phoneline for County Durham and Darlington. (People who need to talk to a doctor when their usual doctors' surgery is closed will phone this number.) We set up this phoneline on 1 October 2009. We have employed an extra 54 staff to cope with the increased number of calls we receive. The staff running this phoneline are based at our headquarters in Bernicia House.

Occupational health – having a healthy workplace

Our occupational health service is dedicated to looking after our employees' health and well-being.

Although fewer people were referred to occupational health in 2009/10 than in 2008/09 our occupational health department have been busy introducing the H1N1 (swine flu) vaccinations, providing health checks to staff, physiotherapy services, occupational-health referrals and assessing people returning to work after sickness.

HOW MANY PEOPLE VISIT THE OCCUPATIONAL HEALTH DEPARTMENT EACH YEAR, FROM 2006 TO 2010

	2006 / 2007	2007 / 2008	2008 / 2009	2009 / 2010
Number of people seen by the occupational health department	**2229**	**2102**	**4736**	**3803**

Promoting good health and well-being

We work hard to promote physical and mental well-being among our staff. For example, we arrange events on stress awareness and cholesterol, check employees' blood pressure in mobile clinics, hold weekly diet clubs and give our employees access to a foot-health practitioner.

We also provide a counselling service for our staff and can support them if they need help with any problems they are having at work or at home. The rapid response counselling service, available seven days a week, offers staff support when they need it. Our counselling service also works with local support agencies to help employees, for example, with drug and alcohol problems.

We recently attended the North East Better Health at Work Awards, where we won the bronze award.

Learning and development

We have continued to support our staff through providing appropriate and forward-thinking ways for them to learn and develop. We run courses, both in-house and through partnerships with training providers, universities and colleges. We also encourage staff to learn through visiting relevant websites and listening to podcasts. We have staff who are studying on undergraduate and postgraduate courses, in both clinical and non-clinical subjects. We continue to develop new accredited programmes for learners, with the Health and Social Care Award being available in the trust this year. By providing these courses and ways to learn, we can make sure our staff have the right skills to continue to provide excellent services to patients, both now and in the future.

Quality in education

We make sure that we provide high-quality education at our trust. We also try to get value for money from the courses we buy from learning providers. In 2009, we received the Matrix award for providing excellent information, support, advice and guidance in personal development and learning for all staff throughout their time working for us. The Matrix standard involved a demanding assessment which took place over three days at the end of October 2009. We will continue to make sure we meet and go beyond the Matrix standard while we work towards achieving the award again in 2012.

Thinking about how we can improve for success in the future

We have a good track record of gaining funding from the Workforce Development Innovation Fund over recent years to support forward-thinking education projects. In 2009 we set up a mobile training unit. The unit will give students a more realistic environment to train in, which will better prepare them for working in an emergency situation. The unit will also have a small study area and a health information area.

We are committed to improving the quality and efficiency of the services we provide. In 2009, we began to put into place a plan to improve our services, developed by the North East Strategic Health Authority, based on experience from the health-care sector in the United States. We hope that by putting this system in place we can improve how we provide services and, most importantly, create a culture of continuous learning and improvement. These aims are closely linked to our vision and values, particularly as we move forward towards foundation trust status. All our staff have been involved in our aim to provide the right care, in the right place, at the right time. We have developed a plan to train our staff how to put this aim into place. We have also set up an improvement team.

As a result of workshops held over the year, we have really improved the quality of our services, and how we provide them. We have also got better value for money for the services and improved our risk management system.

Commercial training team

The team offer training courses in first aid for members of the public and staff and continue to make good progress, beating their targets to raise money for our PCT for three years in a row.

Recently, they have provided courses on how to care for people who have been traumatised to Northumbria Police, Northumberland Fire and Rescue and Durham and Darlington Fire Service. The team have also developed a course for prison officers. Local prisons are considering using this care package. We continue to provide training packages to a wide range of customers working in health care and the private sector.

In line with new legislation, by 2013, patient transport staff who drive our large vehicles must have, as well as our own training qualification, a Driver Certificate of Professional Competence. We aim to provide the training for this qualification. Once we have trained all our staff, we will advertise this training to other organisations to raise extra income.

Moving our call staff to Hebburn

Our new contact centre in Hebburn opened on 1 October 2009, replacing the centre on Teesside and supporting the main centre at our headquarters in Newcastle. Our human resources (HR) department worked in partnership with our call-centre staff to make sure that staff who had to move from Tees to Hebburn were able do so. If contact-centre staff could not move from Teesside to Hebburn, we found different jobs for them at Teesside.

Managing absence

We are committed to reducing the number of employees who are absent because of sickness. This year, we have done the following to tackle absence.

- Put into place a new attendance management policy
- Trained all our managers on the best practice to follow when employees are absent because of sickness
- Prioritised treatment for employees with muscle injuries or fractures and improved the physiotherapy we provide to employees
- Developed monthly absence figures and information for our operations division showing absences at station level

As a result of the above, the number of absences has significantly reduced, and our staff now have access to more occupational health services.

Involving our staff in changing our trust for the future

We think it is important to make sure our staff are informed and involved in improving the services we provide. Below are some examples of how we have consulted and involved our staff.

- We have held roadshows around the North East to explain our plans to become a foundation trust and encourage staff to be active members of the organisation.
- Our improving working lives champions continue to meet twice a year to look at the results of the yearly national NHS staff survey and to develop an action plan to make improvements.
- The Chief Executive and board executive directors continue to visit ambulance stations throughout the trust area.

We also have an effective joint consultative committee (JCC) with good management, staff and union relationships. During the year, the JCC have been involved in discussions about the changes we have made and changes we want to make to develop our patient transport services and the work we have done to develop our employee policies and procedures.

All of our senior managers have been involved in planning for how we will provide services in the future. We have held workshops with the board of directors and carried out presentations on developments, which have influenced our long-term business plans.

As part of developing our service strategies we held 10 staff workshops in May 2009, throughout the North East. The workshops were called ‘Shaping the future of the North East Ambulance Service’. The feedback staff gave us was excellent – they talked openly and honestly and gave staff an opportunity to raise any concerns or issues and put ideas forward for our service strategies.

Equal opportunities and human rights

We aim to make sure that we put equal opportunities and human rights at the heart of our services. We want to do this so that they become part of how we work day-to-day. We aim to be seen as a model employer in terms of providing equal opportunities and to make sure that we treat all staff, patients and carers with dignity and respect. Our equality and diversity team are in charge of this area and the equality and diversity group continue to oversee and monitor how well we are working in this area.

Single Equality Scheme and Action Plan

Our single equality scheme provides guidelines for us to follow so we make sure we provide a high-quality service to everybody, whatever their sex, age, race, disability, sexuality or faith. The scheme sets out our commitment to taking equal opportunities, people's differences and human rights into account in everything we do, whether we are providing services, employing people, developing policies, communicating, consulting or involving people in our work. The scheme explains how we meet our responsibilities according to equal-opportunities laws. We developed the scheme after consultation with staff and local people. The scheme contains an action plan which shows what we must do over the next three years to provide equal opportunities. 2010 is the second successful year of the scheme. We report on our progress in June each year, in the scheme's annual report.

Here are some of the things we have achieved this year by following the scheme.

NHS Employers Equality and Diversity Partner
We have recently been selected by NHS Employers, as one of only 23 trusts to become an Equality and Diversity Partner for 2010/11, in recognition of our commitment to put equal opportunities, people's differences and human rights first at our trust. As an NHS Employers Equality and Diversity Partner we will help to develop good practice both within the NHS and across the public sector.

Stonewall's Top 100 Employers
We were listed as a top-performing organisation in Stonewall's yearly Workplace Equality Index. We were ranked 70th in Stonewall's 'Top 100 Employers of 2010'. (In 2009 we were ranked as 133rd.) The index is a national benchmark that shows the UK's top employers for lesbian, gay and bisexual employees. The index looks at how well employers include lesbian, gay and bisexual employees, both in the way they work and in their policies and procedures. Only five of the top 100 employers were NHS organisations, and we were the only NHS organisation in the region to make the top 100. Stonewall praised our Sexual Orientation Equality Policy and our Dignity at Work Policy and services.

Placement scheme award
For the second year running we took part in an award-winning scheme providing placements for teenagers with learning disabilities in the Sunderland area. Sunderland City Hospitals NHS Foundation Trust, run the scheme, working with local specialist schools and local employers, including us. They provide six-week placements for these pupils, who are often excluded from national work-experience schemes.

Accreditation of the 'Two ticks' Disability Symbol
This year, we continue to hold our Disability Award from Jobcentre Plus. We have continued to show our commitment to providing equal opportunities to people with disabilities by, for example, our Interview Guarantee Scheme for disabled job applicants.

Training our staff about equal opportunities, people's differences and human rights
We continued to provide training to our staff on equal opportunities, people's differences and human rights. We provided team leaders and all managers with training that was specific to their job role. We provided equal-opportunities training to new employees and included an equal opportunities training course as part of our standard staff-training course.

North East NHS staff networks
We continued to work closely with other local NHS trusts and the North East Strategic Health Authority, to support everybody who works for us. We encourage our staff to communicate with each other through our support networks. These networks give staff an opportunity to talk to each other about their sexuality, race, faith or disability.

Working with our partners and the local community
We are a member of the national Ambulance Diversity Forum and the NHS Staff Council's national Equality and Diversity Group. We continue to work in partnership with other organisations and community groups across the North East, such as the Sunderland Equality Partnership Group and the Newcastle Joint Advisory Group on Physical and Sensory Disability. We supported and took part in community events such as the Newcastle Mela festival (which is based around Punjabi, Pakistani, Bengali, Hindi and other South Asian cultures). We were also involved in Northern Pride, which is a yearly celebration event for lesbian, gay and bisexual people in the region.

Dignity at work
We trained more staff to become Dignity at Work officers and mediators to improve the services we already provide as part of our Dignity at Work Policy. This policy states that staff must treat each other with respect. The policy also gives details of how we protect our employees from bullying and harassment at work. The Dignity at Work officers give confidential and non-judgemental support to staff. If staff are being bullied or harassed, the mediators help to sort out any problems informally.

Our policies and procedures on equal opportunities, people's differences and human rights
We have developed several new policies. The Age Equality Policy shows how we aim to create an environment in which all staff, whatever their age, feel equally welcomed and valued. The policy also shows how we deal with people who discriminate against our employees because of their age. Our new Policy for Carers describes the support system we have in place for employees who are also carers. Our Guidance on Managing Dyslexia in Employment explains how we can support people who have dyslexia or a learning disability through the way we employ people, at work and through any training and development.

Workforce Statistics

The figures below show the percentages of the ethnic groups that make up our workforce and how the percentages have changed over time.

Black and Minority Ethnic Representation

2004	1.72%
2005	1.29%
2006	1.30%
2007	1.44%
2008	0.48%
2009	0.70%
2010	1.40%

2.38% of the local population are from non-white-British groups (National Census 2001).

The percentage of males and females working for us from 2004 to 2010

	Male	Female
2004	73%	27%
2005	71%	29%
2006	68%	32%
2007	67%	33%
2008	64%	36%
2009	65%	35%
2010	65%	35%

Percentage of staff who have told us they have a disability

2008	0.4%
2009	0.5%
2010	0.4%

An estimated 6.5% of the local population are disabled (Office of National Statistics).

CURRENT WORKFORCE DATA

Establishment	FTE
Mar-10	97.80%

Organisation Gender Breakdown	FTE	FTE %	Headcount	Headcount %
Female	704.15	34.82%	769.00	36.07%
Male	1,318.33	65.18%	1363.00	63.93%
Total	2,022.48	100.00%	2132.00	100.00%

Organisation Age Distribution	FTE Male	% FTE Male	FTE Female	% FTE Female	FTE Total	% FTE
16 - 20	11.37	0.56%	8.43	0.42%	19.80	0.98
21 - 25	49.85	2.47%	62.67	3.10%	112.52	5.57
26 - 30	92.00	4.55%	107.28	5.31%	199.28	9.91
31 - 35	148.49	7.34%	144.11	7.13%	292.60	14.42
36 - 40	203.47	10.06%	145.37	7.19%	348.84	17.30
41 - 45	191.20	9.46%	107.07	5.30%	298.27	14.70
46 - 50	191.48	9.47%	63.66	3.15%	255.14	12.62
51 - 55	204.59	10.12%	38.05	1.88%	242.64	12.00
56 - 60	136.58	6.75%	24.95	1.23%	161.53	7.99
61 - 65	85.50	4.23%	2.07	0.10%	87.57	4.33
66 - 70	3.80	0.19%	0.00	0.00%	3.80	0.19

Organisation Length of Service Distribution	Male FTE	Male FTE %	Male Headcount	Male Headcount %	Female FTE	Female FTE%	Headcount	Head-count %
0 - 1 yrs	180.81	8.94%	196	9.19%	108.93	5.39%	122	5.72%
01 - 05	481.70	23.82%	505	23.69%	367.30	18.16%	393	18.43%
06 - 10	213.57	10.56%	218	10.23%	124.21	6.14%	138	6.47%
11 - 15	133.60	6.61%	134	6.29%	32.81	1.62%	36	1.69%
16 - 20	133.07	6.58%	134	6.29%	48.53	2.40%	56	2.63%
21 - 25	74.59	3.69%	75	3.52%	20.70	1.02%	22	1.03%
26 - 30	66.00	3.26%	66	3.10%	0.67	0.03%	1	0.05%
31 - 35	31.00	1.53%	31	1.45%	1.00	0.05%	1	0.05%
36 - 40	4.00	0.20%	4	0.19%	0.00	0.00%	0	0.00%
Total	**1,318.33**	**65.18%**	**1,363**	**63.93%**	**704.15**	**34.82%**	**769**	**36.07%**

Sickness Rate	% of FTE Days
2008/2009	7.24%
2009/2010	6.60%

Black & Minority Ethnic Representation	FTE Male	% FTE Male	Headcount Male	% Headcount Male	FTE Female	% FTE Female	Headcount Female	% Headcount Female	FTE %	Head-count %
Mar-10	12.67	0.62%	13	0.61%	12.43	0.62%	13	0.61%	1.24%	1.22%

Disability Declarations	FTE Male	% FTE Male	FTE Female	% FTE Female	FTE Total	FTE %
No	154.26	7.63%	85.31	4.22%	239.57	11.85%
Not Declared	2.6	0.13%	2	0.10%	4.6	0.23%
Undefined	1,154.47	57.08%	614.85	30.40%	1769.32	87.48%
Yes	7	0.35%	2	0.10%	9	0.45%

Pay Band by Gender	Male FTE	% FTE Male	Female FTE	% FTE Female
Band 1	4.31	0.21%	6.49	0.32%
Band 2	80.73	3.99%	57.23	2.83%
Band 3	474.43	23.46%	283.75	14.03%
Band 4	63.50	3.14%	41.07	2.03%
Band 5	499.32	24.69%	234.99	11.62%
Band 6	109.33	5.41%	37.55	1.86%
Band 7	27.80	1.37%	14.20	0.70%
Band 8A	10.00	0.49%	3.60	0.18%
Band 8B	7.00	0.35%	3.00	0.15%
Band 8C	2.00	0.10%	2.00	0.10%
Band 8D	0.00	0.00%	1.00	0.05%
CEO/Dirs	5.00	0.25%	1.00	0.05%
Other	12.01	0.59%	6.60	0.33%

STARTERS DATA

Starters Gender/BME Detail	FTE	FTE %	BME FTE	BME %
Male	194.8	60.00	7	2.15
Female	130.1	40.00	5	1.54
Total	324.9	100.00	12	3.69

Starters Age Distribution Detail	FTE Male	% FTE Male	FTE Female	% FTE Female	FTE Total	% FTE Total
16 - 20	10.37	3.19%	7.51	2.31%	17.88	5.50%
21 - 25	29.00	8.93%	34.02	10.47%	63.02	19.40%
26 - 30	22.00	6.77%	29.99	9.23%	51.99	16.00%
31 - 35	33.00	10.16%	20.99	6.46%	53.99	16.62%
36 - 40	30.00	9.23%	16.57	5.10%	46.57	14.33%
41 - 45	26.00	8.00%	11.99	3.69%	37.99	11.69%
46 - 50	17.00	5.23%	6.01	1.85%	23.01	7.08%
51 - 55	18.53	5.70%	2.99	0.92%	21.52	6.62%
56 - 60	4.43	1.36%	0.00	0.00%	4.43	1.36%
61 - 65	2.31	0.71%	0.00	0.00%	2.31	0.71%
66 - 70	2.16	0.66%	0.00	0.00%	2.16	0.66%

Starters Religous Detail	FTE Male	% FTE Male	FTE Female	% FTE Female	FTE Total	% FTE Total
Atheism	4	1.23%	4	1.23%	8	2.46%
Buddhism	1	0.31%	0	0.00%	1	0.31%
Christianity	28	8.62%	23	7.08%	51	15.70%
I do not wish to disclose my religion/belief	18	5.54%	13	4.00%	31	9.54%
Islam	2	0.62%	0	0.00%	2	0.62%
Other	3	0.92%	3	0.92%	6	1.85%
Undefined	137	42.17%	87	26.78%	224	68.94%

Starters Sexual Orientation Detail	FTE Male	% FTE Male	FTE Female	% FTE Female	FTE Total	% FTE Total
Gay	1.00	0.31%	0.00	0.00%	1.00	0.31%
Heterosexual	37.15	11.43%	19.00	5.85%	56.15	17.28%
I do not wish to disclose my sexual orientation	15.29	4.71%	22.07	6.79%	37.37	11.50%
Lesbian	0.00	0.00%	1.00	0.31%	1.00	0.31%
Undefined	139.36	42.89%	87.00	26.78%	226.36	69.67%
Other	3	0.92%	3	0.92%	6	1.85%
Undefined	137	42.17%	87	26.78%	224	68.94%

Starters Disabled Declarations	FTE Male	% FTE Male	FTE Female	% FTE Female	FTE Total	% FTE Total
No	0.00	0.00%	0.00	0.00%	0.00	0.00%
Undefined	191.80	59.03%	129.07	39.73%	320.87	98.76%
Yes	1.00	0.31%	0.00	0.00%	1	0.31%
Lesbian	0.00	0.00%	1.00	0.31%	1.00	0.31%
Undefined	139.36	42.89%	87.00	26.78%	226.36	69.67%
Other	3	0.92%	3	0.92%	6	1.85%
Undefined	137	42.17%	87	26.78%	224	68.94%

LEAVERS DATA

Leavers Gender/BME	FTE	FTE %	BME FTE	BME %
Male	78.82	68.27%	1.43	1.24
Female	36.63	31.73%	2.00	1.73
Total	115.45	100.00%	3.43	2.97
Lesbian	0.00	0.00%	1.00	0.31%
Undefined	139.36	42.89%	87.00	26.78%
Other	3	0.92%	3	0.92%
Undefined	137	42.17%	87	26.78%

Leavers Age Distribution Detail	FTE Male	% FTE Male	FTE Female	% FTE Female	FTE Total	% FTE Total
16 - 20	1.00	0.87%	0.00	0.00%	1.00	0.87%
21 - 25	2.43	2.10%	5.76	4.99%	8.19	7.09%
26 - 30	4.00	3.46%	7.00	6.06%	11.00	9.53%
31 - 35	6.00	5.20%	5.50	4.76%	11.50	9.96%
36 - 40	6.00	5.20%	5.17	4.48%	11.17	9.68%
41 - 45	10.00	8.66%	4.20	3.64%	14.20	12.30%
46 - 50	7.11	6.16%	4.00	3.46%	11.11	9.62%
51 - 55	7.83	6.78%	1.00	0.87%	8.83	7.65%
56 - 60	19.00	16.46%	3.00	2.60%	22.00	19.06%
61 - 65	13.30	11.52%	1.00	0.87%	14.30	12.39%
66 - 70	2.16	1.87%	0.00	0.00%	2.16	1.87%

Leavers Religous Detail	FTE Male	% FTE Male	FTE Female	% FTE Female	FTE Total	% FTE Total
Atheism	1.00	0.87%	1.00	0.87%	2.00	1.73%
Christianity	20.80	18.02%	10.60	9.18%	31.40	27.20%
I do not wish to disclose my religion/belief	12.50	10.83%	4.11	3.56%	16.61	14.38%
Other	4.00	3.46%	3.57	3.10%	7.57	6.56%
Undefined	40.52	35.10%	17.35	15.03%	57.87	50.13%

Leavers Sexual Orientation Detail	FTE Male	% FTE Male	FTE Female	% FTE Female	FTE Total	% FTE Total
Gay	0.00	0.00%	1.00	0.87%	1.00	0.87%
Heterosexual	18.80	16.28%	10.60	9.18%	29.40	25.47%
I do not wish to disclose my sexual orientation	19.50	16.89%	6.68	5.79%	26.18	22.68%
Lesbian	0	0.00%	0	0.00%	58.87	50.99%
Undefined	40.52	35.10%	18.35	15.89%	115.45	100.0%

Leavers Disabled Declarations	FTE Male	% FTE Male	FTE Female	% FTE Female	FTE Total	% FTE Total
No	8.00	7.00%	5.00	4.00%	13.00	11.00%
Undefined	70.82	61.00%	29.63	26.00%	100.45	87.00%
Yes	0.00	0.00%	2.00	2.00%	2	2.00%

Leavers by Length of Service	FTE Male	% FTE Male	FTE Female	% FTE Female	FTE Total	% FTE Total
0 - 1 yrs	11.69	10.13%	16.41	14.21%	28.10	24.34%
01 - 05	23.00	19.92%	15.23	13.19%	38.23	33.11%
06 - 10	13.50	11.69%	1.00	0.87%	14.50	12.56%
11 - 15	7.80	6.76%	1.00	0.87%	8.80	7.62%
16 - 20	8.00	6.93%	3.00	2.60%	11.00	9.53%
21 - 25	5.83	5.05%	0.00	0.00%	5.83	5.05%
26 - 30	3.00	2.60%	0.00	0.00%	3.00	2.60%
31 - 35	3.00	2.60%	0.00	0.00%	3.00	2.60%
36 - 40	3.00	2.60%	0.00	0.00%	3.00	2.60%

Leavers by Leaving Reason	FTE Male	% FTE Male	FTE Female	% FTE Female	FTE Total	% FTE Total
Death in Service	1.00	0.87%	1.00	0.87%	2.00	1.73%
Dismissal - Capability	11.43	9.90%	2.67	2.31%	14.09	12.21%
Dismissal - Conduct	2.00	1.73%	2.00	1.73%	4.00	3.46%
End of Fixed Term Contract	1.00	0.87%	2.00	1.73%	3.00	2.60%
Flexi Retirement	4.00	3.46%	0.00	0.00%	4.00	3.46%
Initial Pension Ended	0.00	0.00%	0.00	0.00%	0.00	0.00%
Retirement - Ill Health	3.00	2.60%	0.00	0.00%	3.00	2.60%
Retirement Age	13.30	11.52%	2.00	1.73%	15.30	13.25%
Voluntary Early Retirement - no Actuarial Reduction	1.00	0.87%	0.00	0.00%	1.00	0.87%
Voluntary Early Retirement - with Actuarial Reduction	8.83	7.65%	1.00	0.87%	9.83	8.51%
Voluntary Resignation - Better Reward Package	5.00	4.33%	4.57	3.96%	9.57	8.29%
Voluntary Resignation - Child Dependants	1.00	0.87%	0.00	0.00%	1.00	0.87%
Voluntary Resignation - Health	3.00	2.60%	1.00	0.87%	4.00	3.46%
Voluntary Resignation - In-compatible Working Relationships	1.00	0.87%	0.00	0.00%	1.00	0.87%
Voluntary Resignation - Lack of Opportunities	1.00	0.87%	0.00	0.00%	1.00	0.87%
Voluntary Resignation - Other/Not Known	15.27	13.22%	12.22	10.58%	27.49	23.81%
Voluntary Resignation - Promotion	2.00	1.73%	2.60	2.25%	4.60	3.98%
Voluntary Resignation - Relocation	2.00	1.73%	2.00	1.73%	4.00	3.46%
Voluntary Resignation - Work Life Balance	3.00	2.60%	3.57	3.10%	6.57	5.69%

Providing high-quality clinical care and keeping patients safe at the North East Ambulance Service

Introduction

Ann Fox

Kyee Han

In October, our board approved our trust's plans for becoming a foundation trust. Our business plan outlines our strategy once we become a foundation trust, giving details on how we want to develop our services and manage our finances, and how we want the trust to be managed. Our goals, as set out in our business plan, are to:

- set an example to other ambulance services in how we provide emergency care;
- be a key partner in improving urgent care;
- improve patient transport services;
- be an employer who people really want to work for;
- be secure financially; and
- be a well-managed service able to explain our decisions and actions.

The plan sets out how we will aim to achieve these goals by developing new services over the next five years. In developing these services, we will keep in mind our mission statement – 'Right care, right place, right time'.

An important part of achieving these plans was to set up two new directorates. We appointed Ann Fox as the Director of the Clinical Care and Patient Safety directorate and Kyee Han as Medical Director.

We have a long history of improving the quality of clinical care and of improving patient safety. Our clinical care and patient safety directorate are responsible for developing clinical care. This directorate is central to our commitment to provide the highest standards of patient care. They look after the following.

- Managing clinical risk
- Managing complaints
- Research and development
- Controlling and preventing infection
- Protecting children and adults
- Clinical quality and audits
- Managing medicines
- Patient confidentiality

Commissioning for Quality and Innovations (CQUIN)

'High Quality Care for All', published by the Department of Health, has changed the way NHS service providers are funded by linking the funding they receive to the standards they achieve. So, the better the service they provide, the more funding they will receive. This payment framework is called Commissioning for Quality and Innovation (CQUIN).
The CQUIN framework covers the three stages of quality identified in 'High Quality Care For All'. We are always trying to find new ways of improving the quality of our care and we will keep the following in mind when doing so.

- **Safety**
- **Effectiveness**
- **The experiences our patients have had of the care we provide**
- **The need for services to be forward-thinking**

After talking to our commissioners in February 2009, we agreed to improve a number of schemes throughout the 2009/10 financial year. Every three months, we checked whether the changes we made were successful. The improvements we wanted to make were as follows.

Improving safety

- Reducing the number of clinical records (including GP details) that were inaccurate in order to improve how patients were assessed and treated.
- Monitoring our policies for protecting patients and making sure our staff understand these policies. By doing this, we can raise awareness and make sure children and adults who are

at risk are referred to appropriate social services departments.
- Making sure that National Patient Safety Agency (NPSA) safety alerts were given appropriately within specified time frames.

Increasing how effective our services were
- Improving clinical effectiveness by assessing how well we performed against other ambulance services in the country. This included measuring how we treated patients who:
  - had had a cardiac arrest;
  - had had a heart attack;
  - were diabetic and needed emergency treatment;
  - had asthma; and
  - had had a stroke.
- Showing we were committed to always improving our services by arranging independent research on how long it took our ambulances to respond to emergency calls.

Asking patients what they thought about the care they have received
- Looking at the experiences of our patients by asking them what they thought about the care they received.
- Making it easier for patients to get access to the services of other care providers if this was appropriate.
- Reducing the number of ambulances at A&E departments and referring patients to more appropriate types of care (for example, to urgent-care centres, their GPs and so on). We did this through:
  - our contact centre – using a patient assessment system known as NHS Pathways and a separate directory of all NHS services in the ambulance trust area, known as our Capacity Management System; and
  - our operational crew referrals.

Creating forward-thinking services
- Working with the 'Delivering choice' scheme. This is a three-year scheme that aims to improve services given to patients who are nearing the end of their lives, whatever their illness, so they can be cared for and die in a place they choose.

You can see how we performed against these CQUIN targets in our quality account, which we produced earlier this year.

Care Quality Commission (CQC)

For the first time this year, the Care Quality Commission (an independent health watchdog) measured our performance against national clinical performance indicators.

The CQC's yearly assessment rating is in two parts. Firstly, they assess us by measuring our quality of care against a four-point scale, from 'excellent' to 'weak'. Then, they check how well we are doing financially and measure us against the same four-point scale. The score we receive after this assessment shows how well we are doing in meeting our standards and targets.

In 2009, we were rated as 'good' for the quality of our services and 'good' for financial management.

In 15 out of 20 key indicators for clinical care, we were rated above average for ambulance trusts. We are planning to improve the five areas we did not score as well in (which include some asthmatic and diabetic services). We have been working with:

- paramedics and team leaders through the clinical advisory group;
- clinical care directorate;
- the quality committee; and
- service improvement programmes;

to improve the quality of the care we provide.

Safer Care North East (SCNE)

Our directorate of clinical care and patient safety support the Safer Care North East strategy.

The Safer Care North East strategy focuses on priorities across the North East through involving trusts and commissioners. The strategy was developed by the north east patient safety strategic forum and brings together input from NHS organisations across the region. It reflects both national and local priorities and sets out a development programme for collective areas of work which will further improve the safety of services, whilst at the same time allowing local organisations to take forward their own initiatives. Under this strategy NEASsSCNE research has been carried out to better understand mortality (the number of deaths) and morbidity (causes of deaths). In March 2009, CHKS was asked to research mortality and morbidity. We and the North East Observatory are supporting this research.

We follow SCNE's eight clinical priorities. These are:

- safety;
- cleanliness;
- healthcare associated infections;
- falls;
- protecting vulnerable adults and children;
- mortality;
- care transfers; and
- managing patients after they have been discharged (left hospital).

We are also following the themes in 'Our Vision, Our Future'. By doing this, we hope to improve quality and patient safety in the North East.

The Strategic Health Authority (SHA) have worked with commissioners to significantly increase the focus on patient safety and clinical governance in strategies and AOPs, in line with national quality and safety developments and Safer Care North East. We have agreed regional targets for patient safety with all organisations for 2009/10, as part of trying to improve the quality of the care we provide. To meet these targets, we must be open and straightforward in reporting serious untoward incidents (SUIs), always look for opportunities to learn from organisations we work with and make positive changes as a result of that learning.

North East Quality Observatory

We support the North East Quality Observatory. The observatory was introduced by the Department of Health in 2008. The main aim of the observatory is to support how we measure our success and the areas we need to improve in. The areas they support us in include:

- clinical pathways covered by clinical networks; and
- other clinical areas where we feel we need measures to work towards.

The observatory also aims to improve our ability to spot problems and recognise success in the quality and safety of the care we provide.

When looking at the quality of the service we provide, we use the definition of quality that is used in 'Our Vision, Our Future' (NHS North East, 2008). This means that we not only look at how effective our service is, but also how appropriate it is considering people's needs. We also aim to reduce waste in the system.

We will do the following in providing a high-quality service.

- Make sure our services focus on patients and their needs
- Keep to the 'no waste' principle
- Try our best to introduce new services if patients feel they need a service that we don't currently provide
- Work to international standards of best practice

Reporting clinical incidents

We have well-established policies and procedures that are aimed at identifying and learning from all incidents affecting patients' safety (and other incidents we must report), and improving the way we work to prevent accidents in the future, based on local and national experience. Staff and patients can tell us about incidents in a number of ways (see below).

Clinical risk register – clinical-incident reporting system

This register shows details of incidents, investigations into them and what we have done as a result of our investigations. Operational crews can phone us to report an incident 24 hours a day, seven days a week. Our clinical governance and patient safety committee oversee how clinical incidents are

reported. We put details of any clinical incidents into our general incident reporting system.

General incident reporting system
Our staff can bring any incidents to our attention by filling in an incident report form.

Whistle-blowing policy
We encourage our staff to tell us if they are concerned about a fellow member of staff who is affecting patient care by not working in the way they should.

Professional standards panel
We want to support our staff as much as we can, even when somebody has made a mistake. Although sometimes the mistakes may be so severe, it is seen as negligence, we want to create a 'fair blame' culture. We have created a professional standards panel to look at incidents. The panel is made up of the following.

- Medical Adviser and Director (if they are not available, we will ask somebody from our clinical advisory group to stand in for them)
- Director of Clinical Care and Patient Safety
- Head of Clinical Care and Patient Safety
- Clinical Practice Manager
- Head of Clinical Education and Development
- Paramedic or a team leader or clinical representative with operational experience
- Any other colleagues who staff involved in the incident want to be present for moral support (or a member of the JCC)

When this panel looks at incidents, they find out why they happened and see whether there are any lessons that can be learned from them. We tell our staff about the lessons we have learned through clinical practice and training circulars.

The following are examples of improvements we have made as a result of the professional standards panel meeting to discuss incidents.

- Our staff are more aware of the symptoms of anaphylaxsis (especially as a result of insect stings).
- Staff are more aware of the symptoms of head injuries.
- Our staff fill in patient report forms more accurately.
- Ambulance crews communicate more effectively with hospital colleagues when they arrive at A&E.
- Ambulance crews are aware of how important it is to fill in appropriate referral documents when they do not need to take patients to hospital.

The National Patient Safety Agency (NPSA)
NPSA is a special health authority that was created in July 2001 to co-ordinate all reported incidents from health-care organisations across the UK. This is to help health-care staff learn from mistakes that happen anywhere in the health-care system.

The serious alert broadcasting system (SABS)
The SABS is used to send safety alerts within certain set timescales. The Medicines and Healthcare Products Regulatory Agency, NHS Estates, the National Patient Safety Agency and the Department of Health use this system.

By using the SABS, we have:

- improved how we will deal with swine flu;
- improved how we manage our stock of medicines;
- changed our procedures on controlling infection (such as MRSA and C difficile), by promoting hand hygiene and introducing equipment that can only be used once;
- changed how we treat patients with chest pain;
- made staff aware of the fact that patients on long-term hydrocortisone are prone to getting more severe infections;
- reminded staff about the needs of people who are very ill and reaching the end of their lives;
- improved maternity services in Northumberland;
- given ambulance staff the opportunity to refer patients who do not need emergency care to a number of health-care facilities, including those at Blaydon and urgent-care centres across County Durham and Darlington;
- made our staff aware that they must meet the national clinical performance indicators;
- given our staff alternatives to Buccal GTN;
- made sure our staff were prepared for the changes made across County Durham and Darlington as a result of 'Seizing the Future', which saw Bishop Auckland Hospital change to a 'planned care' facility and both Darlington Memorial and University Hospital taking acute care patients;
- made staff aware that patients on oxygen may not be able to connect their personal supply to our oxygen masks; and
- reminded staff of what they should look for if they think a patient has meningitis.

Joint royal colleges ambulance liaison committee (JRCALC)

We have helped to develop and update the JRCALC evidence-based clinical guidelines. We give these guidelines to every A&E staff member and we make sure we cover them in many of our training programmes.

Clinical advisory group (CAG)

The CAG is a committee. Its members are made up of doctors and senior nursing staff from hospitals across the North East and ambulance service representatives. The group is chaired by our Medical Director and a local A&E consultant is vice chairman. This group meet every 12 weeks to advise on, discuss and monitor our clinical activities. The CAG has supported us in improving the quality of the clinical services we provide. The support they give us helps us see how successful our clinical training is and how it helps our students develop professionally.

This year saw the retirement of Dr T Clarke, who had worked for us as a medical adviser. He was also chairperson of JRCALC. We are very grateful to Dr Clarke for his tireless efforts in developing pre-hospital clinical standards of care, and we wish him a very happy, long and healthy retirement.

Clinical audits

A clinical audit (or assessment) is a continuous measurement of the standards health professionals reach in the work they do. We carry out assessments because we want to improve our work and the results we achieve. We look at written observations and details of treatments on patient report forms and compare them to accepted best practice – currently JRCALC clinical guidelines. We also audit how well the people taking calls in our contact centre perform so that we can make sure they carry out call triage (the medical assessment given to 999 callers) to the appropriate standards. By doing this, we hope to continually improve the services we provide.

Clinical audit programme

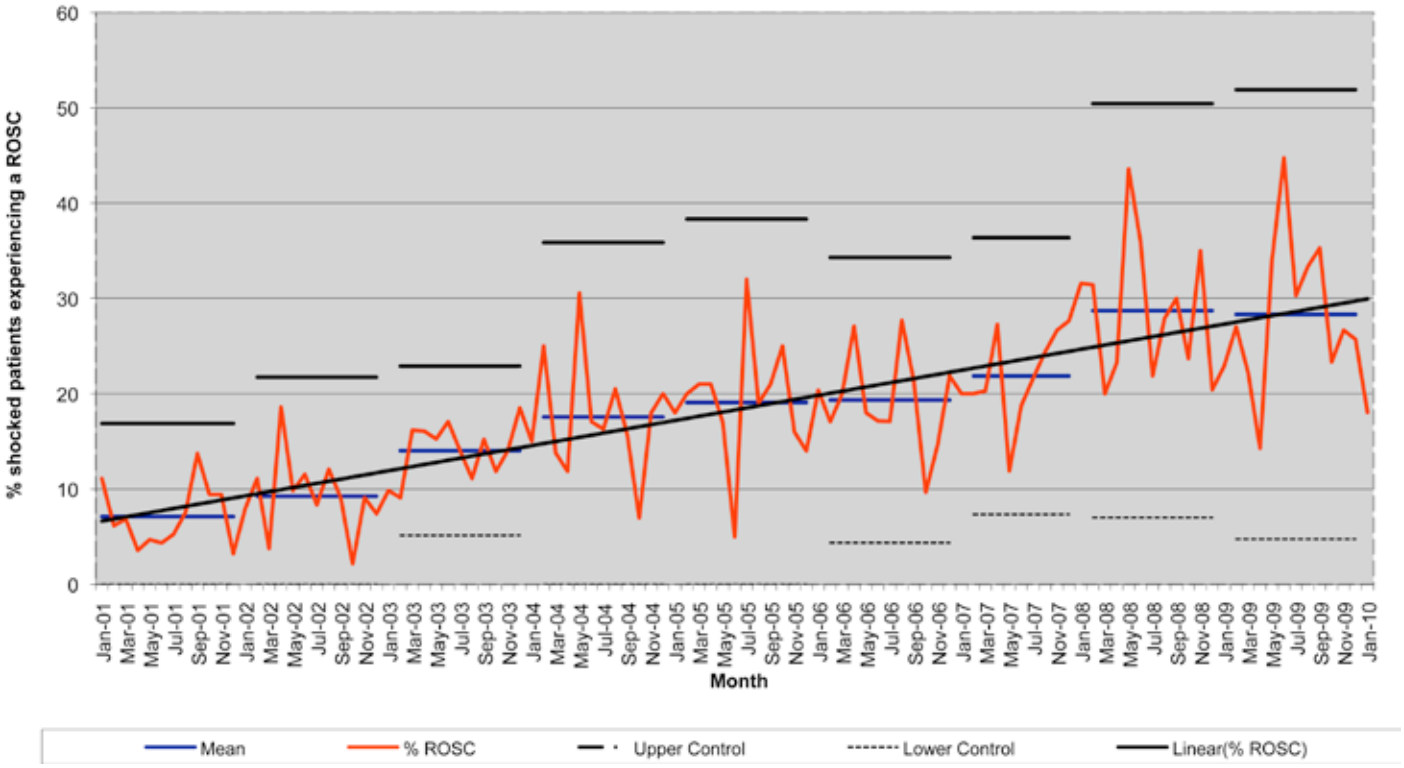
Our clinical audit group decide which areas we will assess each year. This year, we are assessing how well we manage the following in line with the five national clinical performance indicators.

- Diabetic hypoglycaemia (low blood sugar)
- Stroke and transient ischaemic attacks
- Asthma
- Patients in cardiac arrest
- Acute myocardial infarctions (heart attacks)

We send information for an audit every six months for each area we are assessing. We then send full reports to all ambulance services throughout the country. This means each ambulance service can measure their own performance against other services, including ours. They and we can then decide which best practice to follow. In this way, patient care can be improved across the country.

We introduced an improved patient report form on 1 April 2009, after asking our staff what they thought needed to be improved and in line with national guidelines that were introduced at that time. We set up a new scanning and checking system (Teleform) to increase the efficiency of and modernise our clinical audit department. We also set up a new reporting system to compare information from our patient report form with control data in order to analyse a wider range of information.

Cardiac Arrest Patients experiencing a Return Of Spontaneous Circulation (ROSC) on Arrival at Hospital following Defibrilation: January 2001 - January 2010



Clinical performance reporting

We receive clinical key performance indicator (CKPI) reports, which outline the status of clinical activity within the service.

We hold team leader service improvement days, at which we discuss the results of our recent audits. We then write up reports about the audits and send them to staff throughout the trust. In doing this, we hope to improve the level of care we provide.

Research and development

Building on last year's achievements, we have developed a framework for research and development and already developed and approved important research and development documents. Below are some of the achievements we have made in our research and development department.

NIHR portfolio studies
We are currently focusing on two projects.

- NHS pathways (NIHR study reference: 6852)
- Transformational change (NIHR study reference: 27398)

Other projects
We are also working on two non-portfolio projects, on antiemetics and emotional control. We are currently in the planning stages of the following projects.

- How to manage nosebleeds (epistaxis)
- Falls referrals service in the North East
- Mild hypothermia (BIBA study)
- Ultrasound
- Indicators based on the effect of treatment on patients under the care of ambulance service
- How to give CRP instructions over the phone

We have employed a Research and Development Assistant to help support this framework and we are also planning to develop 'research champion' roles.

Our Research and Development Manager represents us at the national ambulance research steering group (NARSG) in London. We believe taking part in this group is vital if we want to design and develop projects in partnership with other ambulance services.

Other developments we have made include entering four summaries of research we had carried out to national conferences. One summary won the 'Research most likely to change practice' award at the 999 Emergency Medical Systems research forum.

- Publish three papers in the Journal of Paramedic Practice
- Set up research and development intranet pages for staff
- Create a monthly newsletter for all staff in the 'Research corner' section of the Pulse magazine

Reducing health-care associated infections

From April 2009, NHS organisations must register with the Care Quality Commission (CQC) under the Health and Social Care Act 2008. As part of our registration, we must protect patients, workers and any other people who may be at risk of catching a health-care associated infection (we call this a HCAI).

We registered with the QCQ in April 2010. Throughout 2009/10 we have continued to make sure our ambulance service keeps to the Health and Social Care Act 2008, and we have suitable systems and arrangements in place to meet our responsibilities.

The CQC made an unarranged visit in July 2009. During their inspection, they found we are keeping to the regulation to prevent people catching a HCAI. They looked at 20 areas and only suggested improvements for three of those areas. We have published a follow-up report and the CQC have told us they do not need to carry out any more checks.

HCAI developments April 2009 – March 2010

To help prevent HCAI, we have introduced:

- colour-coded mop heads that can only be used once, and new handles and buckets;
- intravenous dressing packs, chloraprep and IV Tegaderm semi-waterproof dressing;
- a 'Clean your hands' campaign throughout 2009-2010 (this campaign included fitting alcohol-gel dispensers to all our emergency vehicles);
- PVC paramedic, oxygen and entonox bags that can easily be wiped and cleaned;
- clip watches for paramedics to use so we can keep to Department of Health guidelines about health-care workers having bare skin below their elbows;
- ventilator tubing that can only be used once;
- peak flow meters, which are only used for one patient and then thrown away;
- wound-care packs and fluid to clean wounds;
- 5ml pre-filled saline flush;
- syringe labels;
- dani-centres in sluice areas;
- foot-pedal sack holders for stations;
- cleaning schedules and tasks for sluice and store rooms and information about these on wall displays;
- Clinell sanitising wipe dispensers that we will fit to walls in sluice areas (these wipes are to be used until hand-washing facilities have been built);
- between August and November 2009, assessments to look at how clean our stations are;
- a deep-clean programme to be carried on all stations;
- plans to set up a cleaning contract with an outside company so they can provide cleaning services on our behalf;
- an assessment that will be carried out by operational members of staff (the assessment will include looking at our hand hygiene facilities, whether staff follow the 'five moments for hand-hygiene' guidelines, how we use personal protective equipment, cannulation, how vehicles are cleaned at the start of shifts and after each patient transfer); and
- a sluice project board to give details about the work we are doing to upgrade sluice areas during 2010-2011.

Protecting children and vulnerable adults

We have well-established procedures for protecting children and vulnerable adults. These procedures mean our ambulance crews can put any concerns in writing and fax them direct to relevant social services departments. We then check the referrals have been received. This year, we appointed a Safeguarding Manager who makes sure people across our trust are following our practices to keep children and vulnerable adults safe. Our Safeguarding Manager has built an effective network with partner organisations and has successfully completed the 'Leadership for influence' training course. The Safeguarding Manager also represents us at child-death reviews and vulnerable-adult reviews.

Managing medicines – controlled drugs intelligence network

The Director of Clinical Care and Patient Safety is also our accountable officer for controlled drugs. In this role, she contributes to the County Durham and Darlington controlled drugs intelligence network meetings. We report all controlled drug assessments and incidents (and any investigations made because of the incidents) through this group. They then share information with other health organisations throughout the North East.

In the past year, our pharmacist adviser has been an active member of the new ambulance service pharmacists' network. This group was set up to give pharmacists from ambulance trusts across the UK the opportunity to identify and share best practice. The network's activities this year include:

- contributing to the ambulance service section of the accountable officers handbook (NPC);
- discussing and making clear our procedures in relation to storing, supplying, giving and keeping safe controlled drugs (in an effort to encourage change we have a representative on the Department of Health and Home Office working group which is reviewing the Medicines Act 2003);
- working towards a national framework for ambulance service patient group directions (PGDs);
- producing a document outlining a recommended process for 'verbal orders';
- finding unit dose morphine that offers value for money; and
- reviewing antiemetics and whether they are worth using.

In the past year, our pharmacist adviser also:

- responded to questions about medicines;
- checked and approved PGDs;
- attended CAG meetings;
- helped to prepare the Forensic Medical Examination tender for Northumbria Police;
- contributed to the Designing and Assessing Services for Hyperacute stroke (DASH) trial, including reviewing literature on how drugs should be stored and changes in temperature in emergency vehicles; and
- gave feedback on relevant information from the pharmacists' network.

We have decided to set up a group to manage medicines. This group will report to our clinical advisory group and our clinical governance and patient safety committee. This means we can make sure we have thorough policies and procedures in place to manage medicines.

Caldicott guardian – keeping information safe and sharing information about patients

The Caldicott guardian is a senior member of staff who protects patients' information. They also share information in ways that keep to the Data Protection Act 1998. We still meet the standards set out in Health Service Circular 1999/012 Caldicott Guardians. Currently, the Director of Clinical Care and Patient Safety is the appointed Caldicott guardian.

The following summary sets out how we protect information about patients

We offer both emergency and non-emergency patient transport services to people in the North East. If you use either of these services, we will need certain information about you.

We use your information to make sure you receive the most appropriate treatment and care when you need it. We also use your information to:

- help staff review the care they provide to make sure it is of the highest standard;
- teach and train staff;
- protect the health of the public;
- provide statistics, performance and planning information;
- give information to our commissioners;
- carry out health research and develop services; and
- investigate complaints, legal claims or incidents.

The NHS needs to be able to plan for the future, so they can provide new or better services and they know how many patients to expect. When we analyse information, we do not have access to our patients' names (this means the information we look at is anonymous).

We may also use your information to carry out medical and other health research to research new treatments and develop new services, which will benefit everyone. When we carry out assessments and research, we use anonymous information. Our research is approved by a group of ethics experts before we carry it out.

We have a legal duty to keep information about you confidential. This includes the information you give when you phone 999, the information we keep about you on our computer system, the paper-based records that give details about your care and any conversations you have with our staff. However, there are some exceptions to this. For example, if we believe we must share your information to prevent a child from being harmed, we can do so under the Data Protection Act 1998. There are also some legal exceptions.

The Data Protection Act says we must process information about you 'fairly and lawfully'. This means that you have a right to know how we intend to use the information you provide. It also means that you have a right to privacy, which is respected through any use of your personal information by the NHS.

You have a right to see what information we have about you on our records. If you want to see your health records, write to the Caldicott guardian (see below). If you think some of the information we have about you is wrong, please let us know.

So that we can work with other care providers, we may need to share some information about you. However, we do not give any information that could identify you (for example, your name) to anyone, unless we must to be able to treat and care for you. We will always ask your permission if we need to share this information.

By law, anyone who receives information from us must keep it confidential. We need your permission to pass on any information you give us to your relatives, friends or carers.
Sometimes we must pass on information by law, for example, when a baby is born or somebody dies.

If, for any reason, you do not want us to use your information for research and development purposes, please contact:

The Caldicott Guardian
North East Ambulance Service NHS Trust
Ambulance Headquarters
Bernicia House
Waterfront 3
Goldcrest Way
Newburn Riverside
Newcastle upon Tyne
NE15 8NY.

30 March 2010

Operating and financial review

Estates review 2009-2010

During the year, we did a lot of work to improve our estate. This included the following.

- Building a combined emergency planning and flexibility facility and second contact centre at Hebburn on South Tyneside.
- Introducing a new accident and emergency facility at Grangemouth Fire Station on Teesside in order to reduce the time it takes ambulance staff to reach patients in the Redcar and Cleveland areas.
- Starting work on a new facility in Backworth, North Tyneside and in the North and South of Hartlepool. We hope to finish this by the summer of 2010.
- Continuing our 'Invest to Save' programme by fitting more-efficient boilers and energy-saving light bulbs across our facilities.

Our commitment to the environment

In line with NHS requirements, our Board approved an 'NHS Board Level Sustainable Development Management Plan' at its meeting on 26 November 2009.

Board members have also approved the following action plans, monitored by our environmental management working group (EMWG).

- Fleet - including travel plans
- Buying services and equipment
- Reducing the energy we use and our carbon footprint
- Managing waste and water
- Plans for existing and new buildings

The EMWG make sure we consider the environment in the work we do, while at the same time providing high-quality patient care.

The chairman of the EMWG presented a report on the progress we have made on the sustainable development management plan at a board meeting on 25 March 2010. These are summarised below.

Making our vehicles more efficient

We are planning to buy new vehicles that are fitted with fuel-efficient 'EURO V' engines. These engines mean we will have lower fuel costs and will reduce air pollution.

Introducing a green travel plan

Under this plan, we will do the following.

- Encourage our staff to use public transport by setting up affordable bus travel schemes.
- Set up a car-sharing scheme. We are part of the lift-share scheme, which allows our staff to use our website to advertise the journey they make to and from work. They can send messages to other people at our ambulance service to see if they can travel together and share fuel costs.
- Introduce a bicycle user group to encourage and support members of staff to cycle to work.

Buying services and equipment

We will make the following improvements.

- Change the terms and conditions we give to our suppliers so that they must meet environmental conditions
- Make sure our suppliers keep to our environmental policy and the conditions we use for selecting suppliers
- Through our environmental policy, use products which are less harmful to the environment and encourage suppliers to use less packaging
- Encourage suppliers to use recycled materials
- Avoid using products that can damage the ozone layer
- Encourage the use of energy-efficient equipment and appliances

Reducing our carbon footprint

In 2009-2010, we reduced the amount of carbon dioxide produced as a result of our work by 155 tonnes.

	2009/2010	CO^2 equivalent
Electricity	220,940 kwh	144 tonnes
Gas	48,628 kwh	11 tonnes
Total	269,568 kwh	155 tonnes

Waste

We will do the following to reduce the amount of waste we produce:

- Separate our waste into general waste, cardboard, plastic and confidential waste,
- Work with the Department of Health's consultants (WSP) to improve how ambulance trusts manage waste.

Managing the amount of water we use

We have signed up to Aquafund, an agreement between us and ADSM. ADSM help organisations to reduce their water bills by up to 50%.

Our buildings

We have done the following to improve our buildings.

- Fit more-efficient boilers
- Fit low-energy lighting systems
- Fit PIR detectors (which detect movement) in some areas to switch lights on and off
- Fit more-efficient insulation in older buildings
- Replace windows with more-modern double-glazed units

Our financial performance

This section of the annual report looks at how the trust has managed it's money for the year and performance against mandatory targets.

This year the accounts have been prepared under International Financial Reporting Standards, only the main statements of which are shown here. A complete set of the annual accounts may be obtained from the Head of Financial Services upon payment of a £20 fee.

By law, we must show each year whether we have provided value for money and met our legal duties. We must:

- 'break even' on our income and spending and not get into debt (this means we must only spend the money we have available);
- achieve a 3.5% capital absorption rate; and
- work within our external financing limit (EFL) if we need to borrow money, as agreed with the Department of Health.
- work within our capital resource limit (EFL) if we need to buy capital equipment, as agreed with the Department of Health.

Over the page we show if we met these targets in 2009/2010.

Break Even Duty

The Trust spent £314,000 less on expenditure than it received in income, exceeding the legal duty.

Capital Cost Absorption Duty

The trust is required to absorb the cost of capital at a rate of 3.5% of average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital, totalling £1,327,000 bears to the average relevant net assets of £37,919,000 that is 3.5%.

External Financing Limit

The External Financing Limit (EFL) is a control on net cash flows of NHS trusts. It sets a limit on the level of cash that trusts may:

- draw from either external sources or its own cash reserves – positive EFL or
- repay cash to external sources or increase cash resources – negative EFL

The trust was issued with a positive EFL of £1,421,000 meaning we were able to borrow cash or use our own cash resources by this amount.

As permitted by the Department of Health the trust undershot its EFL, that is, it spent less of it's cash resources/borrowed less than was permissible.

Capital Resource Limit

The trust also undershot its Capital Resource Limit. The Capital Resource Limit is a limit set by the Department of Health on the amount of capital that the trust was allowed to spend in 2009/2010. This was set at £8,911,000. The actual achievement was £8,6000,000 giving an under-spend of £311,000 which is acceptable to the Department of Health.

Management and Administration Costs

Management and administration costs of £4,627,000 represent 4.6% of the trust's income. This represents no change in percentage terms from 2008/09.

Better Payment Practice Code

The Department of Health requires NHS trusts to pay their non-NHS creditors in accordance with the CBI prompt payment code. The target is to pay 95% of non-NHS trade creditors within 30 days of receipt of goods or valid invoice (whichever is later) unless other payment terms have been agreed. The Trust is committed to abiding by this code. The trust paid 97% of its invoices by number and 94% by value within target.

Pension Costs

The provisions of the NHS Pensions Scheme cover past and present employees. The scheme is an unfunded defined benefits scheme that covers NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The scheme is accounted for as if it were a defined contribution scheme: the cost of participating in the scheme for an NHS body is taken to equal the contributions payable to the scheme for the accounting period. The total employer contribution payable in 2009/10 was £6,359,000 (2008/09 £5,951,000).

The scheme is a final value scheme and is subject to a full valuation every four years. A more comprehensive accounting policy note on pension liabilities is included in the full set of the Annual Accounts 2009/10. Information on directors' pension entitlements can be found in the Remuneration Report on page 53 of this annual report.

Financial Risks

Financial risks facing the trust are included in the trust's risk register and are continuously monitored throughout the financial year with regular updates being provided to the trust board.

Patient transport services

From 1 April 2010, primary care trusts took over responsibility for buying patient transport services from hospital trusts. We understand how important it is to show we can provide a good service to patients using the patient transport services. We also recognise the competition from private patient-transport providers. We are currently running a project to transform our patient transport services. This will make the services more flexible while still showing we can give value for money.

We also found that through the payments by results scheme, we ended up being paid too much for accident and emergency services and too little for patient transport services. While it is a good thing that we have this degree of openness, our commissioners may not be prepared to pay the true cost of patient transport services. We are currently talking to our commissioners about the income we will receive for A&E services and patient transport services. We hoped to come to an agreement by 30 June 2010.

National recession

Because of the recession, the Department of Health have asked us to make savings of up to 20% over the 2013/2014 financial year. We will make these savings in the following ways.

(a) Providing the same services with less funding by getting better value for money from the services and equipment we buy.
We estimate that we will need to save £21million from a total budget of around £100million every year over the next five years. This is a big financial challenge and there is a chance the services we provide could be affected.

(b) Finding different ways of providing better services by working together with partner organisations and reducing costs at the same time.

We will decide which areas we will make savings in through following the quality, innovation, productivity and prevention (QIPP) process that was originally set up by the Chief Executive of the NHS in July 2009. We will work with our other primary care trusts, for example, to develop our phone services. We hope to save money by introducing a three-digit urgent-care number so people are not taken to hospital if they don't need to be and so we can give patients more appropriate care.

Audit

The Audit Commission were the trust's external auditors for the year ended 31st March, 2010. Their fee for auditing the accounts was £104,000.

Auditors Local Evaluation (ALE)

The Audit Commission evaluates the standard of the trust's financial and Value for Money systems using a process called the Auditors Local Evaluation (ALE).

The evaluation comprises five elements, namely:

- Financial Management
- Financial Standards
- Financial Reporting
- Internal Control
- Value for Money

The trust received an overall 'good' rating meaning the trust's systems are above the minimum required standards.

Statement of Comprehensive Income

This statement of comprehensive income shows where the Trust receives its money from and where it is spent

The Summary Financial Statements are a summary of the information contained in the Trusts annual accounts.
The full accounts are available on the Trusts website www.neas.nhs.uk.
A hard copy of the accounts can also be requested from the Head of Financial Services upon receipt of a £20 fee.

This revenue is mostly from Accident and Emergency and Patient Transport Services contracts

	2009/10	2008/09
Revenue		
Revenue from patient care activities	97,820	86,341
Other operating revenue	3,569	3,637
Operating expenses	(99,311)	(87,042)
OPERATING SURPLUS	2,078	2,936
Investment revenue	107	239
Interest payable	(145)	(134)
Other finance costs	(447)	(409)
SURPLUS FOR THE FINANCIAL YEAR	1,593	2,632
Public Dividend Capital dividends payable	-1,327	-1,613
RETAINED SURPLUS FOR THE YEAR	266	1,019
Other comprehensive income		
Impairments and reversals	0	(1,234)
Gains on revaluations	1,686	1,326
Receipt of donated/government granted assets	146	0
Reclassification adjustments:		
- Transfers from donated and government grant reserves	(37)	(5)
Total comprehensive income for the year	**2,061**	**1,106**

Includes Commercial Services income for staff training

Approximately 64% relates to our employees' salaries and wages

i.e. income less operating costs

e.g. interest on bank deposits

relates to discounting of costs relating to past early retirement payments and Finance lease costs

These payments are made to the Government to repay the borrowing costs for funding our assets to past early retirement payments and Finance lease costs

This shows we achieved out statutory financial target of breaking even on income and spending and generated a surplus (which will be carried forward to 2010/11)

In addition to the retained surplus -Other Comprehensive Income shows the overall movement on the Trusts Reserves

Balance sheet Statement of Financial Position (SOFP)

The SOFP is a statement of the Trust's assets and liabilities

	At 31 March 2010 £000	At 31 March 2009 £000
Non Current Assets		
Property, pland and equipment	**45,226**	45,541
Intangible assets	**70**	62
Trade and other receivables	**813**	900
Total Non Current Assets	**46,109**	**46,503**
Current Assets		
Inventories	**743**	666
Trade and other receivables	**5,262**	3,618
Cash and cash equivalents	**888**	894
Total Current Assets	**6,893**	**5,178**
Total Assets	**53,002**	**51,681**
Current Liabilities		
Trade and other payables	**(4,277)**	(4,746)
Other liabilities	**0**	(4)
DH capital loan	**0**	(94)
Borrowings	**(397)**	(305)
Provisions	**(447)**	(661)
Net Current Assets/(Liabilities)	**1,772**	(632)
Total Assets less Current Liabilities	**47,881**	**45,871**
Non Current Liabilities		
Borrowings	**(6,545)**	(6,785)
Trade and other payables	**(138)**	0
DH capital loan	**0**	(465)
Provisions	**(2,302)**	(1,786)
Total Assets Employed	**38,896**	**36,835**
Financed by taxpayers Equity		
Public dividend capital	**34,617**	34,617
Retained earnings	**523**	257
Revaluation reserve	**3,613**	1,927
Donated Asset Reserve		34
Government grant reserve	**143**	0
	38,896	36,835

The Trust currently has land, buildings andequipment valued at over £45 million

Stocks are held for use in the day-to-day running of the Trust

The money owed to the Trust at the year end

The money the Trust owes at the end of the year.

This is the money the Trust owes the Governmant on which we pay annual dividends for the use of our estate

This represents an estimate of the annual inflation value of our land and buildings

Signed on behalf of the board

S Featherstone, Chief Executive

R D French, Director of Finance

Statement of Changes in Taxpayers Equity

The Statement of Changes in Taxpayers Equity shows how reserves have changed from one year to the next

	Public dividend capital (PDC) £000	Retained earnings £000	Revaluation reserve £000	Donated asset reserve £000	Gov't grant reserve £000	Total £000
Balance at 31 March 2008						
As previously stated	34,617	(762)	1,836	38	0	35,729
Prior Period Adjustment	0	0	0	0	0	0
Restated balance	**34,617**	**(762)**	**1,836**	**38**	**0**	**35,729**
Changes in taxpayers' equity for 2008/09						
Total Comprehensive Income for the year:						
Retained surplus/(deficit) for the year	0	1,019	0	0	0	1,019
Impairments and reversals	0	0	(1,234)	0	0	(1,234)
Net gain on revaluation of property, plant, equipment	0	0	1,325	1	0	1,326
Reclassification adjustments:						
- transfers from donated asset/ government grant reserve	0	0	0	(5)	0	(5)
Balance at 31 March 2009	**34,617**	**257**	**1,927**	**34**	**0**	**36,835**

All movements of reserves come from the Statement of Comprehensive Income

	Public dividend capital (PDC) £000	Retained earnings £000	Revaluation reserve £000	Donated asset reserve £000	Gov't grant reserve £000	Total £000
Changes in taxpayers' equity for 2009/10						
Balance at 1 April 2009	**34,617**	**257**	**1,927**	**34**	**0**	**36,835**
Total Comprehensive Income for the year						
Retained surplus/(deficit) for the year	0	266	0	0	0	266
Net gain on revaluation of property, plant, equipment	0	0	1,686	0	0	1,686
Receipt of donated/government granted assets	0	0	0	0	146	146
Reclassification adjustments:						
- transfers from donated asset/ government grant reserve	0	0	0	(34)	(3)	(37)
Balance at 31 March 2010	**34,617**	**523**	**3,613**	**0**	**143**	**38,896**

The Trust requested a valuation of it's Property in 2009-10 which resulted in an increase in the value of its Finance Leased buildings

Statement of Cashflows for the year ended

The Cash Flow Statement shows the sources from which cash has flowed into the Trust, the way cash has been used and the net increase or decrease in cash during the year.

Cash flows form operating activities		
Net cash inflow from operations	2,078	2,936
Depreciation and amortisation	6,268	6,824
Impairments and reversals	4,470	1,139
Transfer from donated assert reserve	(34)	(5)
Transfer from government grant reserve	(3)	0
Interest paid	(390)	(411)
Dividends paid	(1,317)	(1,613)
(Increase) in inventories	(77)	(62)
(Increase)/decrease in trade and other receivables	(1,557)	108
(Decrease) in trade and other payables	(263)	(1,488)
(Decrease) in other current liabilities	(4)	(131)
Increase(decrease) in provisions	245	(138)
Net cash inflow from operating activities	**9,416**	**7,159**
Cash flows form investing activities		
Interest received	107	232
Payments for property, plant and equiment	(8,806)	(6,624)
Proceeds from disposal of plant, property and equipment	131	54
Net cash outflow from investing activities	**(8,568)**	**(6,338)**
Net cash inflow before financing	**848**	**821**
Cash flows from financing activities		
Loans repaid to DH	(559)	(94)
Other loans repaid	0	0
Capital element of finance leases	(295)	(268)
Net cash outflow from financing	**(854)**	**(362)**
Net increase/(decrease) in cash and cash equivalents	**(6)**	**459**
Cash and cash equivalents at the beginning of the financial year	**894**	**435**
Cash and cash equivalents at the end of the financial year	**888**	**894**

The main source of cash was from operating activities i.e. mainly from providing healthcare

More than £8 million was spent on our Capital Programme

Funds received from selling properties we no longer use

Other Notes

MANAGEMENT COSTS

	£000	2009 Percent total income	£000	2008 Percent total income
Management costs	4,627	4.6%	4,074	4.6%

BETTER PAYMENT PRACTICE CODE - MEASURE OF COMPLIANCE

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

	2009/10 Number	2009/10 Value	2008/09 Number	2008/09 Value
Total Non-NHS trade invoices paid in the year	18073	30,668	17,563	25,741
Total Non NHS trade invoices paid within target	17440	28,741	16,949	24,499
Percentage of Non-NHS trade invoices paid within target	96%	94%	97%	95%
Total NHS trade invoices paid in the year	803	3,607	805	2,062
Total NHS trade invoices paid within target	785	3,529	785	1,994
Percentage of NHS trade invoices paid within target	98%	98%	98%	97%

STAFF SICKNESS ABSENCE

	2009/10 Number
Total days lost	26,476
Total staff years	1,665
Average working days lost	15.90

National data has been used to populate this note to the accounts.
The data used is for the calendar year 1st Jan - 31st Dec 2009 as a proxy for the financial year 2009-10 which has been agreed by the National Audit Office.

Senior managers' salary and pension entitlements

The following two tables have been audited as part of the annual accounts audit and an unqualified opinion provided.

A) REMUNERATION

Name and Title	Period 1st April 2009 - 31 March 2010			Period 1st April 2008 - 31 March 2009		
	Salary	Other Remuneration	Benefits in Kind	Salary	Other Remuneration	Benefits in Kind
	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100 (£)	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100 (£)
Simon Featherstone Chief Executive	130-135	0	4,100	130-135	0	3,800
Roger French Director of Finance	90-95	0		90-95	0	0
Christopher Harrison Director of Human Resources and Organisational Development	85-90	0	4,100	85-90	0	4,300
Paul Liversidge Director of Operations	85-90	0	2,800	85-90	0	1,400
Colin Cessford Director of Strategy and Business Development	85-90	0	4,100	85-90	0	4,100
Ann Fox Director of Clinical and Patient Safety (from Oct'09)	35-40	0	0	0	0	0
Anthony Dell Chairman	15-20	0	5,900	15-20	0	0
John Pescott Non-Executive Director	5-10	0	0	5-10	0	0
Alison Fellows Non-Executive Director	5-10	0	0	5-10	0	0
Peter Wood Non-Executive Director	5-10	0	0	5-10	0	0
Helen Tucker Non-Executive Director	5-10	0	0	5-10	0	0
Wendy Lawson Non-Executive Director (from Jun'09)	5-10	0	0	0	0	0
Jeffrey Fitzpatrick Non-Executive Director (from Jun'09)	5-10	0	0	0	0	0
Christopher Suddes Non-Executive Director (from Jun'09)	5-10	0	0	0	0	0

Benefits in kind include the provision of a vehicle and a home telephone.

Salary and Pension entitlements of senior managers

B) PENSION BENEFITS

Name and title	Real increase in pension at age 60 (bands of £500) £000	Real increase in pension lump sum at age 60 (bands of £500) £000	Total accrued pension at age 60 at 31 March 2010 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2010 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2009 £000	Cash Equivalent Transfer Value at 31 March 2010 £000	Real increase in Employer Funded Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension To nearest £100
Simon Featherstone Chief Executive	0.5-1.0	1.5-2.0	40-45	120-125	896	1,010	69	0
Roger French Director of Finance	0.0-0.5	-0.5-1.0	35-40	115-120	846	952	63	0
Christopher Harrison Director of Human Resources & Organisational Development	0.0-0.5	1.0-1.5	15-20	55-60	293	340	33	0
Paul Liversidge Director of Operations	0.0-0.5	0.5-1.0	25-30	80-85	437	486	27	0
Colin Cessford Director of Strategy and Business Development	0.0-0.5	-0.0-0.5	35-40	110-115	740	814	37	0
Ann Fox Director of Clinical and Patient Safety (from Oct'09)	1.0-1.5	4.0-4.5	20-25	65-70	274	354	33	0

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

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

The Chief Executive of the NHS has designated that the Chief Executive should be the Accountable Officer to the trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Department of Health. These include ensuring that:

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

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

Simon Featherstone
Chief Executive

10th June, 2010

Statement of directors' responsibilities in respect of the accounts

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

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

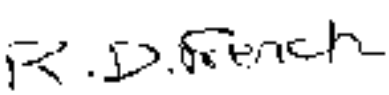
The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They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

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

By order of the Board

Simon Featherstone
Chief Executive

10th June, 2010



Roger French
Director of Finance

10th June, 2010

Statement on Internal Control 2009/10

Scope of responsibility

The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

The arrangements I have put in place to support my responsibilities include the Trust's Assurance Framework. The Assurance Framework identifies the strategic aims and objectives of the Trust and its Directors, taking account of the Standards for Better Health. The principal risks which may impact on the delivery of the objectives and the key controls to manage these risks, have been identified. Action plans to address any gaps in controls have been produced. I have established an Assurance Committee. Part of the remit of this Committee which is accountable to the Audit Committee and Trust Board, is to oversee and monitor the implementation of both the Standards for Better Health, the Assurance Framework and the Organisational Risk Register.

The Trust Board has a Duty of Partnership and as Accountable Officer, I have ensured we have systems and processes in place to work with partner organisations. Both formal and informal mechanisms exist to ensure effective relationships are maintained, and we have met with a number of partners throughout the year, including the Department of Health, North East Strategic Health Authority, Local PCT's, other NHS Trusts, Foundation Trusts, Local Involvement Networks (LINks), community transport providers, voluntary agencies, and Local Authorities in the North East, to name a few.

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 organisation's policies, aims and objectives,
- 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 North East Ambulance Service NHS Trust for the year ended 31 March 2010, and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

The authority to develop and oversee the Trust's strategic risk management arrangements is delegated to the Director of Finance. The Assurance Committee and Clinical Governance & Patient Safety Committee consider non clinical and clinical risks respectively on behalf of the Board however, both the Assurance Framework and the Risk Registers encompass a full spread of organisational objectives and risks. The Directors of the Trust have the responsibility for leadership in Risk Management for their Directorates. Trust managers are responsible for the management of day-to-day risks of all types within their management structure and budget allocation. They are charged with ensuring that risk assessments are undertaken throughout their area of responsibility on a pro-active basis and that remedial action is carried out where problems are identified.

It is the policy of the Trust to provide and maintain, so far as is reasonably practicable, all plant, systems of work (including safe use, handling, storage and transport of substances and articles), places of work and working conditions, such that they are safe and with minimal risks to employees, as well as to non-employees, and to provide such information, instruction and training as is necessary for this purpose.

Risk Management is incorporated in the Trust's Induction Programme. The Risk Management Strategy, policies and procedures and responsibilities are also set out in the Risk Management File, held at all locations and on the IT network for future and on-going reference. General Risk awareness/health and safety training is also provided to all staff on an annual basis according to their level of need/responsibility.

The Trust has representation on the National Ambulance Risk & Safety Forum and is active in the promotion of benchmarking and learning from good practice.

Statement on Internal Control 2009/10 (continued)

The risk and control framework

The risk management framework is set out in the Board-approved Risk Management Strategy. The Trust recognises that it is impossible and not always desirable to eliminate all risks and that systems of controls should not be so rigid that they stifle innovation and imaginative use of limited resources, in order to achieve health benefits for patients.

The strategy describes how risks are identified, via the system of risk registers and an incident reporting system and how they are quantified, using a Risk Scoring Matrix. This allows standardisation of risk assessment across the Trust, utilising a common currency. The strategy also requires action plans to be determined and implemented for those risks that are inadequately controlled. The Trust also has a number of associated policies and procedures embedded in the organisation including an Incident Reporting Policy, Serious Untoward Incident Policy, Complaints Policy and Claims Policy.

Risk Management is embedded within the organisation in a number of ways. All departments within Directorates maintain up to date Risk Registers that are linked to Directors objectives and monitored on a regular basis. All business cases must include a full risk assessment prior to formal approval. Management and operational structures are in place to manage the risks that the Trust faces. All of the current dedicated risk-management committees working within the Trust have risk management incorporated within their remit. The Working Groups/Committees report through Committees of the Board in a structured manner ultimately to the Board.

The remit of four Committees of the Board cover risk (both clinical and non-clinical) these are:

- Assurance Committee
- Clinical Governance & Patient Safety Committee
- Patient Involvement and Complaints Committee
- Audit Committee

The Trust's Director of Finance chairs the Assurance Committee which oversees the creation of appropriate risk assessment systems, including a prioritised risk management plan and reviews and reports progress against this plan, to the Audit Committee and the Board.

It reviews incident trends from financial / non-financial / non-clinical areas and prepares the Assurance Framework, for review by the Audit Committee and approval by the Board.

Clinical Risk is monitored via the Trust's Clinical Governance & Patient Safety Committee. The Trust's Medical Adviser chairs the Clinical Advisory Group. Both groups have access to expert professional opinion from specialist Medical Advisers and Clinicians.

Clinical Risk whilst being everyone's responsibility is managed by operational staff and specialist managers. All clinical practices are carried out using the best available clinical evidence base. This includes; advice that is given to patients over the telephone and advice and skills performed when the paramedic is in a face to face situation. In the former, the evidence base is largely taken from papers published in the UK and for the latter, the evidence base is the Joint Royal Colleges Ambulance Liaison Committees latest Clinical Guideline. Clinical competence is a matter for the Trust's Professional Standards Panel which reviews every complaint, claim and concern, looking for opportunities to learn lessons and protect patients.

The Patient Involvement and Complaints Committee is authorised by the Board to oversee all activity relating to the monitoring of patient's experiences. This includes for example, overseeing their involvement in the activities of the Trust as well as learning lessons from patient complaints and letters of appreciation. The Committee also receives reports regarding the outcome of patient surveys and reports published by the Trust's Patient Advice and Liaison Service (PALS).

The Audit Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities. This includes activities that are both clinical and non-clinical. This integrated approach to governance supports the Trust in achieving its organisational objectives.

The Trust manages its information risks on an ongoing basis via the Information Governance Working Group. On an annual basis, the Trust completes the Information Governance (IG) Toolkit. In 2009/10 the Trust reported an overall score of 68% compliance which is an amber rating. During 2009/10 there were no Serious Untoward Incidents reported for Information Governance.

The Assurance Framework provides the Trust with a comprehensive method for effective management of the principal risks to meeting its objectives including achievement of compliance with the core Healthcare Standards. It provides a structure for evidence to support the Statement on Internal Control and as a result, simplifies Board reporting and the prioritisation of action plans. The Assurance Framework includes the following key elements:

- strategic objectives of the Trust by Directorate linked to the relevant individual Standards for Better Health
- risks to achieving the objectives
- key controls in place to manage the risks
- assurances for the key controls
- evidence of the controls and assurance
- any gaps in control
- any gaps in assurance
- action plans to address the control gaps

The Assurance Framework is approved by the Trust Board at the beginning of the financial year. It reviews the Assurance Framework mid-way through the year and approved the final version at the end of the year.

There were a limited number of gaps in assurance and / or control in the areas of operations, winter planning, information governance, finance, and preparation for foundation trust status and plans were put in place to mitigate or eradicate. The gaps in control were not assessed as being significant.

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

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

The Trust has undertaken risk assessments and Carbon Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on the 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 is fully compliant with the core standards for better health. Internal Audit has reviewed the Standards for Better Health assessment process and is satisfied that the process is robust

Review of effectiveness

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 Assurance Framework and on the controls reviewed as part of the internal audit work. Executive Managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by external assessments and achievements in 2009/10 as follows:

- Internal Audit reports
- Bi-monthly performance reports covering all Directorates in the form of an Integrated Performance Report.
- External Audit reports including the Auditors Local Evaluation, Annual Audit Letter, Annual Governance Report
- Improving Working Lives Practice Plus accreditation.
- External Quality Audits and Continuous Certification to ISO 9001:2000 Standards
- Declaration of full compliance against the core Care Quality Commission Core Standards
- Achievement of Level 1 NHSLA Risk Management Standards for Ambulance Trusts.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the findings and work of the following Groups/Committees:

Statement on Internal Control 2009/10 (continued)

- Board
- Audit Committee
- Assurance Committee
- Clinical Governance & Patient Safety Committee
- Patient Involvement & Complaints Committee

A plan to address weaknesses and ensure continuous improvement of the system is in place.
A brief summary of the main responsibilities the above Committees are outlined below:

The Board: The Chief Executive and Trust Board have overall responsibility for the Trust's risk management programme. It is the Trust Board that endorses and resources all formalised risk management plans.

The Audit Committee's remit includes: To provide the Trust Board with an independent and objective review of its financial systems, financial information and compliance with laws, guidance and regulations governing the NHS.

As the Senior Board Committee, to scrutinise the risks and controls which affect all aspects of the organisation's business and undertake a central role in determining its governance arrangements.

To ensure the Trust's compliance with legislative, mandatory and regulatory requirements in terms of the Committee's scope.

The Assurance Committee's remit includes: To review the establishment and maintenance of effective systems for the assessment and management of risk and quality across the whole of the organisation's activities that supports the achievement of the organisation's objectives.

To oversee compliance with law, best practice governance and regulatory standards and to seek assurances that the Trust's action plans in those respects are robust.

As a formally constituted sub-committee of the Trust Board, to play a key role in the review of the Trust's Risk Management & Organisational Controls Framework and arrangements.

The Clinical Governance & Patient Safety Committee's remit includes: To ensure that an effective framework and environment exists within the Trust to promote excellence in clinical care and through which the Trust can account for continuously improving the quality of its services and safeguarding high standards of care.

To ensure the delivery of the highest quality of care based on clinical evidence and agreed standards.

To ensure the Trust's compliance with legislative, mandatory and regulatory requirements in terms of the Committee's scope

The Patient Involvement & Complaints Committee's role includes: To oversee activity relating to the monitoring of the experiences of patients and their involvement in the affairs of the Trust. This will include learning from complaints and letters of appreciation received, from patients' surveys, from PALS reports and other sources.

To discuss and approve initiatives designed to obtain the views of patients and stakeholders and to oversee activity relating to the communication to patients, staff and other stakeholders by the Trust.

To ensure the Trust's compliance with legislative, mandatory and regulatory requirements in terms of the Committee's scope.

Conclusion
My review confirms that the North East Ambulance Service NHS Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

No significant internal control issues have arisen during the period.

Simon Featherstone
Chief Executive (on behalf of the Board)

Independent auditor's statement to the Board of Directors of North East Ambulance Service NHS Trust

I have examined the summary financial statement for the year ended 31 March 2010 which comprises the Statement of Comprehensive Income, the statement of Financial Position, the Statement of Cash Flows, and associated notes in respect of Management costs, Better Payment Practice Code and staff sickness absence.

This report is made solely to the Board of Directors of North East Ambulance Service NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 49 of the Statement of Responsibilities of Auditors and of Audited Bodies prepared by the Audit Commission.

Respective responsibilities of directors and auditor
The directors are responsible for preparing the annual report.

My responsibility is to report to you my opinion on the consistency of the summary financial statement within the annual report with the statutory financial statements.

I also read the other information contained in the annual report and consider the implications for my report if I become aware of any misstatements or material inconsistencies with the summary financial statement. The other information comprises only the Chairman's Introduction, the Chief Executive's End of Year Statement, Ambulance Operations, Foundation Trust, Community Involvement, Complaints and Letters of Appreciation, Workforce, Clinical Care and Patient Safety, Operating and Financial Review, summary Financial Targets, financial Performance, Trust Board, Past, Present and Future and the unaudited part of the Renumeration Report.

I conducted my work in accordance with Bulletin 2008/3 'The auditors' statement on the summary financial statement in the United Kingdom' issued by the Auditing Practices Board. My report on the statutory financial statements describes the basis of my opinion on those financial statements.

Opinion
In my opinion the summary financial statement is consistent with the statutory financial statements of North East Ambulance Service NHS Trust for the year ended 31 March 2010.

Cameron Waddell
Officer of the Audit Commission

Nickalls House
Metro Centre
Gateshead
NE11 9NH

10 July 2010

Trust board

Trust Board

The board of directors of North East Ambulance Service NHS Trust has fifteen members: a Chairman, five Non-Executive directors and two Non-Executive director (designates) and seven Executive directors; one of whom is the Chief Executive. Its composition represents much of its catchment area, with members from Northumberland, Darlington, Stockton, Sunderland, Tynedale, Newcastle, North Tyneside and Cleveland.

The role of the board is to:

- provide active leadership of the organisation
- set its strategic direction and aims, ensuring that both financial and human resources are in place, and
- to monitor and review management performance.

The board also determines the organisation's values and standards and ensures these are maintained in the conduct of the business of the whole organisation. All board members subscribe to the 'Codes of Conduct and Accountability in the NHS'. A key function of the board is to ensure that there is effective dialogue between the local community on its plans and performance.

The board meets formally at least six times a year and members attend bi-monthly seminar events where a range of themed developmental sessions and briefings are delivered.

The Roles of Executive and Non-Executive Directors

Non-Executive directors contribute to the development of strategy and have an important role in scrutinising the performance of management in meeting agreed goals and objectives and monitoring the reporting of performance. Non-Executive directors are drawn from the local community and therefore, have a particular duty to it - they can ensure that the voice of the public is heard in decision-making and that the interests of patients and the community remain at the heart of board discussions. Non-Executives also have a role in working with the Chairman in the appointment and remuneration of the Chief Executive and other board members, as members of the Trust Remuneration Committee.

Executive Directors share the same corporate responsibilities as Non-Executive colleagues but bring detailed knowledge of the organisation's management systems and processes and of the health sector, as well as specialised clinical and managerial expertise.

Leadership Arrangements and Committee Structure

As reported by the Chairman in his introduction to this Annual Report, much of the board's attention has been focused upon monitoring the quality of our services to ensure that high standards of care are maintained during a period of significant organisational development as the trust prepares for foundation status. A major review of the trust's governance arrangements was undertaken during the latter part of the year and the board was restructured to ensure that we had the mix of experience, skills and attributes to ensure we would be fit for the future, not only as a foundation trust but also in the context of the demanding financial environment.

The Trust reviewed its executive director portfolios during 2009 in preparation for a foundation trust application. As a result the following Directorates were established:

- Chief Executive
- Operations
- Finance
- Clinical Care & Patient Safety
- Workforce & Organisational Development
- Strategy & Business Development

As a result, there were five new members appointed to the trust's board of directors. On the 'executive' team, Ann Fox, a qualified nurse, has joined us as Director of Clinical Care & Patient Safety (October 2009), working alongside Mr Kyee Han, a consultant in emergency medicine, as Medical Director (January 2010 on a part time basis. There have been no resignations during the year.

On the Non-Executive side, Chris Suddes, Wendy Lawson and Jeff Fitzpatrick, who bring considerable relevant acumen in areas such as transport logistics, telephony, call-centre management and commercial activities to the board.


Simon Featherstone


Roger French


Colin Cessford


Paul Liversidge


Christopher Harrison


Ann Fox


Kyee Han

As the senior board committee providing independent scrutiny, the Board agreed changes to its committee structures during the year in order to better integrate its governance arrangements and to ensure it effectively addresses the challenges and opportunities of the changing policy environment for the NHS at large.

A number of existing committees that fall within the risk management and organisational framework were merged, and a new Board-level Committee was created; bringing together income generation, service development/strategic commissioning and efficiency activity. This new Business Investment and Strategy Committee which includes Non Executive Director membership, has developed its Terms of Reference and continues to review its Agenda as it becomes embedded in the organisation.

All Non Executive Directors are members of the Trust's Audit Committee. This is chaired by John Pescott. It has met seven times, discharging its responsibilities that include:

- review of the Annual Report and Financial Statements
- review of internal financial and management reporting systems
- review the establishment and maintenance of an effective system of risk management and internal controls
- review the adequacy of all risk and control related disclosure statements – in particular the Statement on Internal Control and Compliance with the Standards for Better Health
- review the adequacy of the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, including Trust Protocols
- review the provision of Internal Audit service and the work and findings of the External Auditor including the monitoring of work plans

The committee reviewed, before submission to the board for approval:

- financial accounts and statements;
- Statement on Internal Control, and
- Annual Health Check declaration

The committee has worked with the Audit Commission to further improve the arrangements already in place and strengthen its performance in readiness for potential foundation trust status and is working through an action plan to assist in this process.

Another key committee that is made up of Non-Executive Directors is the Remuneration & Terms of Service Committee (but this includes the Trust Chairman). It has met twice during the year. Its role is to review the terms and conditions of employment of the Executive Team, assess performance and recommend salary changes. The Chief Executive also attends meetings for that part of the meeting that concerns the members of the Executive Team but not where matters relate to the Chief Executive post.

The trust Chairman agrees objectives with, and reviews the performance of individual Non-Executive directors, as does the Chief Executive; with Executive members of the board and progress is reviewed individually on a quarterly basis; reported annually to the Remuneration & Terms of Service Committee.

The board reviews its own performance annually. During the latter part of the year, it continued its development work to build a confident, capable and cohesive board that is equipped with the skills and competencies required to successfully and effectively govern an NHS Foundation Trust.

The team of Executive and Non Executive Directors during 2009/10 comprised:

Executive directors

Simon Featherstone - Chief Executive
Roger French - Director of Finance
Colin Cessford - Director of Strategy & Business Development
Paul Liversidge - Director of Operations
Christopher Harrison - Director of Workforce & Organisational Development


Tony Dell


John Pescott


Helen Tucker


Peter Wood


Alison Fellows


Chris Suddes


Wendy Lawson


Jeff Fitzpatrick


Joel Byers

Ann Fox - Director of Clinical Care and Patient Safety (since October)
Kyee Han - Medical Director (since January)

Non Executive directors

Tony Dell (Chairman)
Tony has just been re-appointed as Chair of the trust for a further four year period. Tony was the Chairman of the former organisation and prior to that, a Director with the Government Office for the North East (GONE) for ten years, taking early retirement in 2000.

John Pescott (Vice Chairman)
John has an accountancy background and is the Royal Danish Consul for Newcastle. Having served an initial 3 years with the trust, he too was re-appointed for a further three years to the Board on 1 July 2010.

Helen Tucker
Helen took up her post with the Trust on 1st October 2007 and was appointed for a three year period. She brings a wealth of diverse experience to the board having worked within the NHS for forty years, starting her career as a Cadet Nurse and finally retiring from the post of Director of Patient Service and Nursing for a former local PCT. Helen retains a strong professional interest in the dignity of patient care and pain control.

Peter Wood
Peter spent 39 years working for Barclays Bank before his retirement since when he has been actively engaged in a range of community activities. Peter was appointed for a period of three years on 19th July 2006 and has been re-appointed for a further three years.

Alison Fellows
Alison took up her post at the inception of the new Trust for a period of three years. She is the Head of Major Project Development with Newcastle City Council and worked as a Non-Executive for the former NEAS Trust. Alison was re-appointed in June 2009 for a three year term.

Chris Suddes
Chris worked at board level in public and private logistics companies for over 20 years. Becoming semi-retired after a road accident in 2001, he gained an MBA at Sheffield University then served as a Non-Executive director at North Sheffield PCT. Initially joining as a Governor he then became a Non Executive Director on th Board of Sheffield Teaching Hospitals Foundation Trust before moving back to his native North East in 2007. He owns a small consultancy business, is Chairman of Deploy (an organisation working with employers on disability issues) and is a Non-Executive Director of Patient Opinion. He lives in Newcastle.

Wendy Lawson (designate)
Following a long and successful career in sales and business development, Wendy moved into the contact centre arena where she worked at a senior level for several years. Wendy now runs her own contact centre Consultancy based in Newcastle. Her main areas of interest include telemarketing and outsourcing, specialising in senior operations management and project management of high volume contact centres. Wendy took up her role with the trust on 1 June 2009

Jeff Fitzpatrick (designate)
Jeff started his career in Human Resources and industrial relations and quickly moved on to general management. Jeff has a passion for investment and recently formed a new venture, World Class Investors Ltd. through which he is helping people who need to boost their pension investments. Jeff is a significant investor in the world's stock markets himself and enjoys teaching others how to do so safely and successfully. Jeff took up his role with the trust on 1 June 2009

Staff Representative

Joel Byers
Joel attends all Board meetings as a representative of the Joint Consultative Council (JCC); aimed at representing the views of all staff in board deliberations affecting them.

Declaration of Interests

It is a requirement that the Chairmen and all board members should declare any conflict of interest that arises in the course of conducting NHS business. Upon appointment members are asked to declare any business interests, directorships, positions of authority in a charity or voluntary body in the field of health and any connection with contracting bodies for NHS services. All such declarations are entered in a register and are available for public scrutiny. The following interests have been declared by board members:

Alison Fellows is an employee of Newcastle City Council and her husband, Tim, is a partner in Dickinson Dees Law Firm.

Peter Wood is Chairman and Trustee of Charlotte Straker Project (Care Home) which is a charitable company. He is a Director and Trustee of St Oswald's Hospice

Helen Tucker has recently agreed to undertake voluntary work with Tees Esk & Wear Valley Mental Health Trust as an associate hospital manager; reviewing patients who have been sectioned under the Mental Health Act.

Jeff Fitzpatrick is a Director of three limited companies: Ecopanel Systems, The Executive Director and World-Class Investors and is a Trustee of Darlington & District Youth and Community Association.
Chris Suddes is a Director of four limited companies: Antipas Design-works, Phoenix Folk, St Ann's Quay Management and Patient Opinion (an NHS user forum) and a non-executive director chair of Deploy Ltd.

Kyee Han is a Trustee of the Great North Air Ambulance Service.

Ann Fox is a Company Director with the Communication Equation Ltd (providing communications training to non-health and social care related organizations) and Trustee of 'My New Hair Charity'.

Wendy Lawson is a Director and sole shareholder of Consultants in Contact Ltd which offers management services to Contact Centres and has declared the interests of her sister in relation to a private partnership offering mediation and education services, a national charity promoting safe-professional boundaries, her work as a caseworker with the Parliamentary & Health Services Ombudsman and also with the Cleveland Police authority's Standard Committee as an independent member.

Past, present and future

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The history of our trust

Our trust was formed on 1 July 2006. We brought together the North East Ambulance Service and part of the Teesside, East and North Yorkshire Ambulance Trust.
Our service cover the counties of Northumberland, Tyne and Wear, Durham and Teesside, an area of around 3230 square miles. We employ almost 2000 people and serve a population of 2.6million.

The work that we do

We provide accident and emergency (A&E) and non-emergency patient transport for people in the north east of England.

In 2008/09 our 999 control and contact centres answered 405,000 emergency and urgent calls. Our rapid response and two-crew A&E vehicles attended more than 340,000 incidents and patient transport crews carried out almost 1.1 million patient journeys across the region.

Our buildings

Our headquarters are on the Newburn Riverside business park, to the west of Newcastle upon Tyne city centre.

We moved to these headquarters in January 2008 as part of moving our A&E and PTS contact centres.

The other administrative services of our trust are also based in the headquarters building, named Bernicia House after the ancient kingdom of Bernicia which stretched from the Scottish borders to North Yorkshire in the sixth century – roughly the same geographical area as the area our trust covers.

Throughout the region there are 63 trust locations, including 51 ambulance stations. A number of the stations also house the non-emergency patient transport service employees and vehicles.

We share some of our sites with the fire service in an effort to of more areasreduce costs. Because the area we cover is made up of urban and rural areas, we use various types of vehicles to cope with the different road conditions. In total, we run over 450 vehicles. We also use helicopters funded by the Great North Air Ambulance, when they are available. We have 184 non-emergency vehicles within the patient transport service. These vehicles travel more than four million miles every year.

We also have 100 volunteers, called ambulance car service drivers, who use their own vehicles to take patients to hospitals. They make around 194,000 journeys each year.

If you ask us to, we can send you a copy of this report in large print, Braille or on audiotape.

We can also translate it into other languages.

Please contact:

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