Freedom of Information Request

18 January 2023

Question

I would like to know:

For each of the following years: 2020, 2021, 2022 to date 14/12/2022 - how many Significant Adverse Event Reviews (SAERS) have been initiated where the event
involved

a) A patient death in an ambulance outside A&E?

b) A patient coming to harm while in an ambulance outside A&E?

Clarification was requested on the definition of harm in the given question.

Response provided, “any form of “harm” that would trigger the initiation of a SAER (a significant adverse event)”

“For example, you could provide figures on number of SAERs where the incident was non-fatal (in addition to providing numbers where the SAER related to a death)”

Alternatively, in some health board areas I understand that harm in the context of SAERs can be defined as “major harm” – meaning that intervention was required to sustain life or a patient being left with some form of long-term disability/incapacity requiring medical treatment.”

Answer

Please see the details below of where a Significant Adverse Event was launched, meeting the criteria specified.

For the given data, you will see that some of the figures are shown as, five or less than five, please note that this figure has been suppressed because the statistical value is less than five. The Scottish Ambulance service has a duty, under the Data Protection Act to avoid directly or indirectly revealing any personal details. It is therefore widely understood that

provision of statistics on small numbers, five or less are statistically suppressed upon disclosure.

a) Patient death recorded to happen in or outside A&E in Ambulance.

Please note caution on the interpretation of this data, the figures provided below have been given from our reporting system where the specific data criteria you have requested is not held, though through review we have determined the following,

2020 – 0

2021 - <5

2022- <5

b) **A patient coming to harm while in an ambulance outside A&E?**

we can confirm the figures provided above are the same answer to provide for part b of your request.

2020 – 0

2021 - <5

2022- <5

The review of SAERs is a key part of SAS' Clinical Governance Framework.

In mid-2020 we set up a new Learning from Events group which has membership from front line clinicians across the Service. The group is actively encouraging more reporting across the Service so that we can learn from events. Learning from such reviews contributes to improvements in patient safety and experience. It also helps us optimise our response and equip our clinicians to deliver the best possible care. Details of reviews and associated

actions are shared with our Clinical Governance Committee as well as details of family / carer engagement and involvement.

We publish our annual Duty of Candour report, which provides additional information, into the public domain. A copy of which can be found at our publications section of our Website: Reports (scottishambulance.com) Reports (scottishambulance.com)

Working Together for Better Patient Care