Scottish Ambulance Service

Working in Partnership with Universities

NHS SCOTLAND

SCOTTISH AMBULANCE SERVICE
DUTY OF CANDOUR ANNUAL REPORT

1 Introduction

All health and social care services in Scotland have responsibilities under The Duty of Candour Procedure (Scotland) Regulations 2018. This is a legal requirement which means that when unintended or unexpected events happen that result in death or harm as defined in the Act, those affected understand what has happened, receive an apology, and that organisations learn how to improve for the future.

An important part of this duty is that Health Boards provide an annual report about how the Duty of Candour responsibilities have been implemented in our services. This short report describes how The Scottish Ambulance Service has operationalised the Duty of Candour requirements during the time between 1 April 2022 and 31 March 2023.

2 About the Scottish Ambulance Service

At the frontline of the NHS in Scotland and with over 6,400 members of staff, we provide an emergency ambulance service to a population of 5.4 million people serving all of the Scotland's mainland and island communities. We are responsible for a range of services for the people of Scotland from accident and emergency response, to delivering primary care, providing patient transport, dispatching air ambulance and SCOTSTAR support for critical patients, to being a Category 1 responder for national emergencies.

Last year we received over 1.5 million calls and responded to over 520,000 emergency incidents. In a more planned way, our Patient Transport Service undertakes over 403,000 journeys every year, which dropped over the last year due

to the necessary cancellation of clinics during the pandemic. Linking patients to specialist service provision across health board boundaries is a key area of our work and we undertook 4,527 Air Ambulance missions and 33,643 inter Hospital transfers.

3 Number and Nature of Duty of Candour incidents

Between 1 April 2022 and 31 March 2023, there were 26 incidents where we applied the Duty of Candour legislation. These are unintended or unexpected incidents that result in death or harm as defined in the Act, and do not relate directly to the natural course of someone's illness or underlying condition. In considering these incidents it is often not possible to be certain that the circumstances of the incident had a causal effect in terms of harm, however in the spirit of the legislation we have included cases where we are unable to determine this point fundamentally.

We identify through the significant adverse event review process if there were factors that may have caused or contributed to the event, which helps to identify Duty of Candour incidents. There may be occasions where Duty of Candour may not be carried out due to lack of contact details of the patient and/or family, or where the principle family contact is through a partner organisation.

Nature of unexpected or unintended incident where Duty of Candour applies	Number
A person died	23
A person suffered permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	
Harm which is not severe harm but results or could have resulted in:	
An increase in the person's treatment	3
Changes to the structure of the person's body	
The shortening of the life expectancy of the person	
An impairment of the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days	
The person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days.	
The person required treatment by a registered health professional in order to prevent:	
The person dying	
An injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.	

4 To what extent did The Service follow the Duty of Candour procedure?

When we realised the events listed above had happened, we were fully compliant with Duty of Candour guidance in 20 out of the 26 occasions. This means we informed the people affected, apologised to them, and offered to meet with them. In each case, we reviewed what happened and what went wrong to try and learn for the future.

For 4 of the incidents, we were unable to identify any family members to contact. For 1 incident it was inappropriate to make contact and for the remaining 1 incident we are reviewing the procedures followed during the review process.

We have amended our reporting processes to ensure that family contact, when families can be identified, is now a mandatory element of our reviews and a review cannot be concluded without family engagement.

5 Information about our policies and procedures

Every adverse event is reported through our local reporting system as set out in our Adverse Event and Duty of Candour Policy. Through our adverse event management process, we can identify incidents that trigger the Duty of Candour procedure.

Each adverse event is reviewed to understand what happened and how we might improve the care we provide in the future. The level of review depends on a number of factors, including the severity of the consequence of the event as outlined in our policy. However, beyond the duty applied to us within the Act, we apply the principles of open and honest communication that underpin the Duty of Candour legislation to all Clinical Reviews carried out within the Service.

Recommendations are made as part of the adverse event review and we develop improvement plans, as incident reviews are taken through our Clinical Governance processes. We track the completion of these actions centrally through our Adverse Event Reporting System.

The method of dialogue used to engage with those parties affected is managed dynamically. As can be expected, the level of engagement and the ways in which we engage with the affected parties can vary, based on individual circumstances. Our principle in engaging with those affected is to do this based on the wishes of those affected. That can include engaging in person, face to face or by phone, in writing or through an appropriately agreed third party. Not only do we seek to engage with the affected parties, we offer those affected the opportunity to influence recommendations for improvement, in order to robustly ensure that as well as being open and honest, we can really ensure that the views of those affected align to agreed improvement actions.

All relevant managers receive one to one training on how to manage an adverse event on the reporting system and also on implementation of the Duty of Candour Legislation so that they understand when it applies and how to trigger the duty.

We know that adverse events can be distressing for staff as well as people who receive care. We have support available for all staff through our line management structure as well as through Occupational Health Services. This means that staff can contact a confidential telephone line to speak to trained counsellors. We have also developed a wellbeing strategy which we are currently implementing.

6 What has changed as a result?

We have made and are planning a number of changes following review of our adverse events within 2023-2024 and these are listed below:

Actions relating to Handover Delays

- We are reviewing the activities that we are undertaking to improve hospital turnaround times and are reengaging with Scottish Government and partners regarding what is feasible given the system pressures.
- We are working with local health boards to optimise handover times at receiving Hospitals.
- We concluded work with an NHS Board to improve patient flow throughout the hospital through the “90 day process”.
- We have implemented a flow navigation centre with the NHS Board, to allow patients to be seen and admitted without attendance at the Emergency Department (ED) and therefore increase ambulance availability.
- We requested and are assisting the NHS Board to incorporate a risk assessment in their existing escalation/major incident guidance. This assessment will consider the risk to patients in the community, alongside the risk to patients currently in the emergency department. This will be used when the ED is experiencing high workload or when ambulances are queuing.
- We have implemented national best practice guidance in relation to a range of factors regarding hospital handover delays.
- We are reviewing and developing updated guidance around clinical care and communication between the Service and ED interface when patient handover is delayed.

- We have devised and published mechanisms and guidance for cohorting care which can now be considered if demand and capacity threshold triggers are met.

Action relating to Demand and Capacity

- We are continuing to improve resource and vehicle availability with the aim of improving response times to patients in urgent need of assistance through full implementation of the demand and capacity programme.

Actions relating to our Ambulance Control Centre's

- We have implemented the Integrated Clinical Hub within our Ambulance Control Centre (ACC) and are designing and delivering clinical support / supervision processes.
- We are reviewing the clinical capacity within the ACCs to support incoming calls to ensure the safety netting of waiting calls.
- We are reviewing the management of calls in the teal stack (low acuity) when a duplicate yellow (higher acuity) call is received.
- We are considering how clinical input can be made available at the earliest opportunity when merited in calls.
- We are purchasing a module for our command-and-control system which would enable our staff to see a snapshot of resources in a timely manner to minimise risk.
- We have carried out a review of the advice we give about accessing public access defibrillators.
- We are reviewing the guidance for review times within the Timed Admission calls, with Clinical Advisors being asked to contact the scene as close to the call going out of time as possible to improve patient safety.
- We are in the process of recruiting Clinical Support Advisors to support the demand in calls requiring re-triage and Patient Transport Service suitability checks when demand is high.
- We are reviewing the dispatch and clinical supervision arrangements for lower acuity calls where allocated ambulances are diverted to patients within a higher acuity code.

- We are completing a review of the on-call policy to ensure that it is fit for purpose for Island working where only a single vehicle and crew may be based. This will include dispatch criteria for during the on-call period.
- We carried out refresher training for dispatch and supervisor grades of staff across the ambulance control centre's regarding the application of Standard Operating Procedures.
- We have reviewed the clinical stack management process and prioritisation of incidents.
- We reissued guidance to all call handlers across the ambulance control centre's regarding the agonal breathing tool.
- We carried out a review of the duplicate call process.
- We are reviewing the 'Unable to Triage' Process taking cognisance of the increased vulnerability of patients who are alone.
- We are reviewing how the service manages unwell patients on trains.
- We are re-issuing and engaging with Healthcare Professional colleagues around the Ambulance Booking Guide and the importance of not devolving the booking of an ambulance to a patient.
- We are improving guidance around when it is appropriate for call handlers to highlight incidents to Call Handling Supervisors for advice when a referral to an alternative pathway is suggested.
- We have developed pragmatic guidance for dispatchers and incident commanders in relation to releasing resources promptly from incidents. This area has also been built into dispatcher and incident commander training.
- We are reviewing the Card 46 (patient transport) safety netting procedures to consider their appropriateness and effectiveness.
- We have reviewed the patient outcome data related to stroke codes to ensure optimal categorisation.

Actions relating to Clinical Guidelines

- We are reviewing our current maternity guidelines around breech presentations, with particular focus on unplanned breech births in primigravida (first pregnancy) patients.

- We have established a working group to consider methods of safe moving and handling of patients in active labour (potentially aimed at slow progressing births).

Actions relating to Staff Education and Training

- We are providing further guidance to ambulance Technicians on where appropriate professional to professional decision-making support can be sought.
- We are considering how to embed the principles of effective documentation and responsibilities pertaining to documentation.
- We have considered how to embed the guiding principles outlined in the Clinical Decision-Making framework across the clinical workforce.
- As part of Statutory and Mandatory training staff and team leaders were provided with a reminder in relation to attending purple calls and the standards expected.
- We published a staff bulletin advising staff to stop the practice of crews swapping over at handover times.
- We have included Cognitive Bias education specifically within the Clinical Decision-Making Framework and its educational content within a Continuous Professional Development (CPD) program on clinical decision making for staff.
- We are working with local obstetric units to improve communication, exploring the options of having dedicated 24-hour SAS emergency phones within each individual unit. We are also considering an automatic alert being sent to receiving maternity units when a birth is imminent. This may allow rapid opening up of communications between crews and receiving units.

Actions relating to Communication

- We have implemented personal issue communication devices to frontline staff. This was to eliminate the concerns over bringing personal devices into infectious environments.
- We reviewed how the Service can ensure that Bulletin Boards are kept up to date to allow staff to have easy access to pertinent information and updates.

- We have reviewed current processes to optimise staff access, utilisation, and application of clinical practice guidelines.
- We have audited and reviewed Clinical staff access to emails and implemented a process to ensure that agreed access is achieved.

7 Other information

As required, we have submitted this report to Scottish Ministers and we have also placed it on our website.

If you would like more information about this report, please contact us using these details: sas.corporateaffairs@nhs.scot.