Scottish Ambulance Service
Taking Care to the Patient

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 2019 and 31 March 2020.

2 About the Scottish Ambulance Service

The Scottish Ambulance Service is a national service which provides pre-hospital emergency and urgent care, scheduled care through our patient transport services (PTS) and transfers between healthcare facilities. We employ over 5,000 highly skilled staff and receive over 960,000 emergency contacts per year through our Ambulance Control Centre network of which around 650,000 result in an emergency ambulance response. In a more planned way, over 660,000 patients are taken to and from hospital by our Patient Transport Service each year and our Air Ambulance service deals with more than 3,600 incidents per year. Linking patients to specialist service provision across health board boundaries is a key area of our work and we transport over 48,000 patients each year between hospitals in Scotland, by road and

air.

The Service occupies a unique position and role within health care provision in Scotland and seeks to continuously build on the strengths of our traditional and emerging service provision, in the context of a continually changing health and care system. We are a 24/7 mobile service meeting the scheduled, unscheduled and emergency care needs of a diverse population.

3 How many incidents happened to which the Duty of Candour applies?

Between 1 April 2019 and 31 March 2020, there were 10 incidents where the Duty of Candour legislation applied. 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.

The Scottish Ambulance Service identified these incidents through our adverse event management process. Over the time period for this report we carried out 18 significant adverse event reviews.

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. Due to the COVID 19 pandemic a number of reviews took longer than expected, however we have carried out a review of all relevant incidents during this time.

Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition)	**Number of times this happened (between 1 April 2019 and 31 March 2020)**
A person died	7
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	
A person's treatment increased	3
The structure of a person's body changed	
A person's life expectancy shortened	
A person's sensory, motor or intellectual functions was impaired for 28 days or more	
A person experienced pain or psychological harm for 28 days or more	
A person needed health treatment in order to prevent them dying	
A person needing health treatment in order to prevent other injuries as listed above	
TOTAL	

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

When we realised the events listed above had happened, we followed the correct procedure in 7 out of the 10 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.

We have reviewed the 3 occasions where we did not follow the Duty of Candour procedure. For two of these, despite our best efforts, we could not identify anyone to communicate with who was affected by the incident and in the third case we are reviewing the procedures followed during the review process.

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. We have also tailored our Adverse Event Reporting System to support the Duty of Candour procedure with additional guidance contained within the policy.

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. The service also developed a family liaison course for managers who are regularly key points of contact with people who have been affected by an adverse event and we

are currently developing a course for managers on how to conduct difficult conversations.

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 19-20.

- We are reviewing our Demand and Capacity work plan, the outcomes of which will be implemented by 2022 with high risk areas prioritised. This will ensure that SAS resources are aligned to current demand and the modelling suggests that this will significantly reduce delays in response and also improve staff experience.
- We are looking to strengthen system processes to ensure we accurately understand when a crew is at the scene of an incident.
- We are reviewing our Consent Policy to ensure it is fit for purpose.
- We will ensure education related to a step-wise assessment of patients' mental capacity to make decisions is embedded in all relevant education programmes.
- We will ensure the Service's Safeguarding Group provides pragmatic guidance for ambulance clinicians on the management of patients who are intoxicated and are in need of clinical care but refusing assistance, or not cooperating but remain vulnerable.
- We have implemented safety netting advice to provide clarity that extends to patients who have refused aid as well as those who have been referred or discharged by the ambulance service.

- We are introducing a feedback process for staff regarding their clinical documentation completion to drive quality improvement.
- We have carried out an audit and review of the availability of required lifting equipment, particularly lifting cushions, to front line crews when required.
- We issued a Bulletin to all staff as a reminder to inform safe manual handling practice and decision making.
- We are reviewing the process relating to extended response times to ensure cross border vehicles are considered.
- We are formalising the Stack Coordinator role within our Ambulance Control Centres to ensure patients are regularly triaged, safety netting applied and response escalated where unable to contact.
- We are reviewing the use of the protocol for sending resources with Police Scotland, to consider options to change to a process where police officers make or facilitate direct calls to Ambulance Control Centre from scene utilising the 999 system, or the Ambulance Control Centre make direct contact with those on scene.
- We are evaluating the trial of clinical advisor waiting emergency call co-ordination role.
- We are reviewing the process of identifying relevant calls with reference to intentional overdose to ensure they are appropriately reviewed by the ACC Clinical Advisors within agreed timeframes to consider quantity, timings and toxicity of medications (utilising Toxbase), and appropriate escalation takes place when required.
- We liaised with Health Boards regarding 'hospital turn around times' at local Emergency Departments where delays result in reduced ambulance availability for people in communities.
- We are looking to Implement 'Card 47' (Mental Health Transfers and Admission Protocol) within our Ambulance Control Centre and relevant communications plan for health and social care stakeholders.
- We are establishing a SAS/NHS24 Quality and Safety Group, to jointly review the process by which all calls are transferred between NHS24 and SAS to ensure safe and appropriate levels of response are embedded within both organisations.

- We are reviewing the dispatch process by which staff close calls within Ambulance Control Centre, paying appropriate attention to the clearing of warnings within the incident prior to closure.

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: scotamb.CorporateAffairs@nhs.net.