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 2021 and 31 March 2022.

2 About the Scottish Ambulance Service

At the frontline of the NHS in Scotland and with over 6,227 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 1.6 million calls and responded to over 527,000 emergency incidents. In a more planned way, our Patient Transport Service

undertakes over 420,000 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 4,138 Air Ambulance missions and 32,491 inter Hospital transfers.

3 Number and Nature of Duty of Candour incidents

Between 1 April 2021 and 31 March 2022, there were 22 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	20
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	1
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.	1

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 16 out of the 22 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 one incident, family contact was carried out by a territorial board partner. For 2 of the incidents, we were unable to identify any family members to contact. For the remainder of the incidents, 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 2021-2022 and these are listed below:

Demand and Capacity

- We are implementing our Demand and Capacity programme to enhance resource levels.
- We are implementing the recommendations from the recent ORH demand and capacity review, particularly in relation to staffing coverage.
- We are ensuring the ongoing Demand and Capacity review includes options to safely balance both regular demand patterns and short notice/term increases to levels of demand. This is to ensure capacity for both ACC safety netting, operational response and staff welfare.
- We are reviewing the vehicle provisions dedicated to Timed Admission's calls within the in and out of hours periods to ensure vehicle availability and rosters are aligned to the demand.
- We are working with Health Boards to optimise handover times at receiving Hospitals. This work has been underway for several months now and specific improvement actions and interventions have been agreed and implemented.

Staff Education

- We established a process with representatives of ambulance technicians to co-propose the support mechanisms required to ensure safe decision-making.

- We are updating guidance in Resource Planning Business Rules to ensure that different internal student cohorts are defined and provide clear guidance on the prioritisation of rostering internal students with paramedics.
- We have ensured continued awareness across our workforce of the newly qualified paramedic (NQP) role to ensure staff awareness of appropriate skill mix.
- We are reviewing and refreshing guidance relating to when it is appropriate to carry out staff welfare call / interventions and to identify the triggers for when these are required.
- We have included reference to cognitive biases and the red flag five in the updated SAS Clinical Decision-making Framework.
- We will incorporate the key aspects of the red flag five guidance in ambulance clinician patient assessment education and development.
- We are reviewing our current processes to optimise staff access, utilisation, and application of clinical practice guidelines.
- We are implementing a feedback mechanism to enable frontline staff to develop and maintain their skills in clinical & shared decision-making.
- We raised awareness of Adult Protection processes within all regions and ACC to ensure that staff are informed and supported through this process when dealing with someone who is vulnerable
- We are ensuring SAS clinicians continue to follow the current recommendation from the RCPCH in relation to the conveyance of patients under 2 years until such time as there is a change in national clinical guidelines.

Remote Triage

- We are exploring the option of providing the facility for GPs to directly book patients into the C3 system e.g. through an App/access to the system.
- We have implemented a Clinical Hub Escalation Process in line with the National Escalation Policy which supports stack coordination and maximises the number of triages undertaken when staffing levels are low or incident volume is high.

- We ensured Yellow category calls receive a timely clinical review by reviewing current escalation procedures and clinical code set for Advanced Practice telephone assessments.
- We are reviewing the educational and practice support arrangements for SAS clinicians providing remote clinical care and triage.
- We have implemented a process to record all remote consultation calls.
- We are reviewing guidance with the local Emergency Department around how professional-to-professional decision-making support calls are structured and develop best practice guidance.
- Development of a red flag list specific to remote consultation. This education and best practice guide will include advice regarding timely safety netting and appropriate community pathway referral.

Ambulance Control Centre Actions

- We reviewed our end of shift standard operating procedure and provided support in implementing these procedures to our Ambulance Control Centre staff.
- Have shared learning with other UK Ambulance Services to ensure that any learning regarding effective use of buddy site arrangements are optimised.
- We are reviewing Ambulance Control Centre arrangements to identify whether information from clinicians at scene could be managed through a more efficient process.
- We have improved access to senior clinical support for SAS clinicians.
- We are reviewing the Timed Admissions Welfare Call Back Process to ensure staffing levels are adequate and align to the frequency of the call backs required.
- We are reviewing how calls received from other ambulance services/trusts from within the UK, are shared to improve accuracy of information and timely response.
- We have updated operational practice relating to use of Emergency Locator systems (eg ‘What Three Words’) within ACC.
- We have reviewed our escalation plans at the clinical impact and actions to be taken within the call back process.

- We have reviewed the Urgent Dispatch function.
- We have reviewed processes in ACC for safety netting incidents related to sepsis.
- We are engaged with the supplier of our ACC systems to develop an audit tool for allocation of resources
- We ensured all dispatchers understand the process in relation to Paramedic Response Unit deployment.
- We use reflective learning and individual/process review on warning systems within all ACC's to raise awareness on existing process.
- We support dispatchers around regular assessment and documentation when no ambulance is available to attend an incident.
- We are moving the location of the incident and the postal code area within C3 to present on the dispatch screen with the crews who are closer.
- We re-issued call handling instructions for the agonal breathing tool.
- We are reviewing opportunities for improvement in support for paramedic advisors.
- We are reviewing the technological/operational interface between the ACC and Transport hub.
- We have requested that the International Academies of Emergency Dispatch consider implementing timeframe guidance into protocol 12 – seizures, when call handlers are waiting on the line, where normal recovery time is not known. SAS MPDS Guidance – protocol 12 to be updated thereafter in response as required.
- We are implementing a robust system to ensure that SAS ACC process guidance instructions are implemented and stored in a consistent way to ensure they are accessible to staff, and to maximise application as intended.
- We are exploring if a system electronic flag or alert can be incorporated, to minimise occurrences of an available resource being missed by a dispatcher for a yellow call.
- We are evaluating implementation of a system in ACC to ensure shift coverage and timings match current demand.
- We have updated the ACC 'unable to contact' escalation process.

Impact of the Covid-19 Pandemic

Due to the Covid-19 Pandemic there were limitations on face-to-face engagement and therefore the Service had to create virtual opportunities to have discussions with patients and families whilst ensuring a person-centered approach was maintained. The arrangements put in place were mutually agreed on an individual case basis.

The impact of the pandemic also meant that it took longer for the Service to review cases due to the ongoing pressures of dealing with Covid-19.

The virtual opportunities created by the impact of the Covid-19 pandemic remain an option to consider for future engagement with patients and families.

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.