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 2020 and 31 March 2021.

2 About the Scottish Ambulance Service

At the frontline of the NHS in Scotland and with over 6,300 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 1.3million calls and responded to over 493,000 emergency incidents. In a more planned way, our Patient Transport Service

undertakes over 660,000 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 transported over 41,000 patients last year between hospitals in Scotland, by road and air.

3 Number and Nature of Duty of Candour incidents

Between 1 April 2020 and 31 March 2021, there were 16 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 23 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 and therefore not all SAERs are classified as Duty of Candour events.

Nature of unexpected or unintended incident where Duty of Candour applies	Number
A person died	15
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	
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.	1
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 followed the correct procedure in 14 out of the 16 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 2 occasions where we did not follow the Duty of Candour procedure. For one of those we are reviewing the procedures followed during the review process and the other case is currently being reviewed by the Procurator Fiscal Services who will be carrying out this 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. The service also developed two courses over the last year. The first one '*human factors and systems thinking to learning from events'* which is based on the Systems Thinking Everyday Work (STEW) principles and the second course *'how to have difficult conversations with patients and families involved in the adverse event*

review process and create psychological safety in conversations with staff'. These courses will continue to be delivered throughout 2021-2022 as operational pressures allow.

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 2020-2021.

- We are progressing our Demand and Capacity work plan, the outcomes of which will be implemented by 2022 with areas prioritised based on identified need for additional resourcing. 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 liaised with Health Boards regarding 'hospital turn around times' at local Emergency Departments where delays result in reduced ambulance availability for people in communities. A 'whole system' approach to reducing ambulance delays has been proposed.
- We implemented a new process within our Ambulance Control Centres (ACC) to optimise our response to GP and inter facility transfers. The new process optimises the type of resource required for the patient, based on the clinical information received from the GP, allowing SAS to support these patients with a wider range of resources than before. We are evaluating this new process during 2021 to ensure that all opportunities to improve patient experience are being realised.

- We have redesigned the way in which we respond when patients who have called us cannot be found and are currently auditing this new process to ensure that it meets the needs of our patients.
- We are reviewing with Emergency Departments how professional-to-professional decision-making support calls are structured and we will develop best practice guidance to share more widely.
- We issued a National Training Bulletin to all SAS clinicians, highlighting the actions, indications and contra-indications of certain specific medicines. This was to improve safe medicines use and we share this learning across UK Ambulance Services where appropriate.
- We continually review our clinical coding to optimise the timely dispatch of resources. This review looks at high volumes of clinical data, but also takes into account individual case reviews and person-centred considerations.
- We have reviewed and re-issued the Healthcare Professional booking guide for healthcare professionals to use when contacting SAS.
- We have optimised the working environment within ACC to ensure specialist support for staff is easily accessible and interruptions are minimised.
- We have introduced a number of changes to the way SAS Advanced Practitioners (AP) work when consulting remotely. These include improved system access, recording of consultations, the use of video where desirable and the ability for clinicians across the country to work remotely and flexibly with full access to the ACC systems.
- We are developing education for clinicians around improving the quality of consultations, particularly when managing stressful situations.
- We are implementing further education and training through our learning in practice programme for 2021 the safety netting principles and good practice that are covered within the SAS Clinical Decision-Making framework. These are closely aligned to the principles of Scotland's 'Realistic Medicine' strategy.
- We have implemented an Escalation Process within ACC to maximise the number of triages / safety calls undertaken when staffing levels are low or incident volume is high.
- We have introduced a number of interventions to improve call handling and optimise system effectiveness, including some technical elements of guidance

and also liaising with the International Academy of Emergency Dispatch where our reviews have identified system issues where improvements could be made.

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 by all parties and continued through the engagement process to ensure the Scottish Ambulance Services commitment to place people at the heart of health and care services in Scotland was maintained. As restrictions eased the Service ensured that when face-face meetings were taking place all social distancing guidelines were followed and that all parties involved were comfortable with the arrangements put in place.

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, however there were no instances of the duty of candour procedure being activated which are directly attributable to Covid-19.

The virtual opportunities created by the impact of the Covid-19 pandemic will be 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.