1 Introduction

All health and social care services in Scotland have a duty 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, the people 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 we provide an annual report about how the Duty of Candour is 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 2018 and 31 March 2019.

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 between hospitals in Scotland, by road and air annually.
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 2018 and 31 March 2019, there were 8 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 9 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.
<table>
<thead>
<tr>
<th>Type of unexpected or unintended incident (not related to the natural course of someone’s illness or underlying condition)</th>
<th>Number of times this happened (between 1 April 2018 and 31 March 2019)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A person died</td>
<td>7</td>
</tr>
<tr>
<td>A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions</td>
<td></td>
</tr>
<tr>
<td>A person’s treatment increased</td>
<td>1</td>
</tr>
<tr>
<td>The structure of a person’s body changed</td>
<td></td>
</tr>
<tr>
<td>A person’s life expectancy shortened</td>
<td></td>
</tr>
<tr>
<td>A person’s sensory, motor or intellectual functions was impaired for 28 days or more</td>
<td></td>
</tr>
<tr>
<td>A person experienced pain or psychological harm for 28 days or more</td>
<td></td>
</tr>
<tr>
<td>A person needed health treatment in order to prevent them dying</td>
<td></td>
</tr>
<tr>
<td>A person needing health treatment in order to prevent other injuries as listed above</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>4</strong></td>
</tr>
</tbody>
</table>

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 6 out of the 8 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 these, despite our best efforts, we could not identify anyone to communicate with who was affected by the incident and of the second case we are actively attempting to make contact.

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 the severity of the event as outlined in our policy, however, the principles of Duty of Candour are applied to all Clinical Reviews carried out within the Service. It also gives parties an opportunity to actively engage with us throughout the SAER process.

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.

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 has 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. We intend to further develop and spread this course.

We know that adverse events are not only distressing for people who receive care, but can also be distressing for our staff. We have therefore provide support to 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.
6 What has changed as a result?

We have made a number of changes following review of our adverse events within 18-19.

- We implemented a Clinical Decision Making Framework with associated protected time for staff training and education. This includes guidance on patient assessment, shared decision making and safety netting for patients who are managed in communities rather than taken to the Emergency Department.
- We have implemented a new process in the Ambulance Control Centres (ACCs) called ‘dispatch on disposition’ which enables more effective dispatching of resources, and more accurately identifies our most critically ill patients earlier in the triage process.
- We are developing, in partnership with other healthcare providers, a new process for Call Handlers within our ACC in processing Health Care Professional enquiries.
- We implemented a new welfare ring back process for Clinical Advisors within ACC to contact patients who experience delays in response.
- We have implemented dispatch prompts within the New Clinical Response Model (NCRM) to ensure automatic back up of Paramedic Response Units, who are single responders, when they are sent to Immediately Life Threatening calls, reducing delays in transfer to definitive care.
- We issued revised guidance to ensure appropriate back up arrangements are in place for paramedic response units to ensure that the clinical requirements for a timely response are clearly communicated.
- We have put an electronic link in place between The Service and Northern Ireland Ambulance Service to reduce time delays in passing 999 calls in times of increased demand when calls are transferred between Services. These are part of UK wide business continuity arrangements to ensure the reliance of 999 ambulance response.
- We circulated a national clinical bulletin to staff communicating the need to route patients to the Emergency Department when a Stand By call is required even if the initial destination was e.g. a receiving ward.
- We implemented a system for Ambulance clinicians to access previous ambulance attendances, improving access to important information that can support safe clinical decision making.
- We have reviewed the demand management arrangements within ACC and introduced new, more flexible demand management arrangements.
- We upgraded our ACC system and reviewed the coding of calls.
7 Other information

This is the first year of the Duty of Candour being in operation and it has been a year of learning and refining our existing adverse event management processes to include the Duty of Candour outcomes.

We have submitted this report to Scottish Ministers and we have also published it on our website.

If you would like more information about this report, please contact us using these details: scotamb.CorporateAffairs@nhs.net.