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 report describes how The Scottish Ambulance Service has operationalised the Duty of Candour requirements during the time between 1 April 2023 and 31 March 2024.

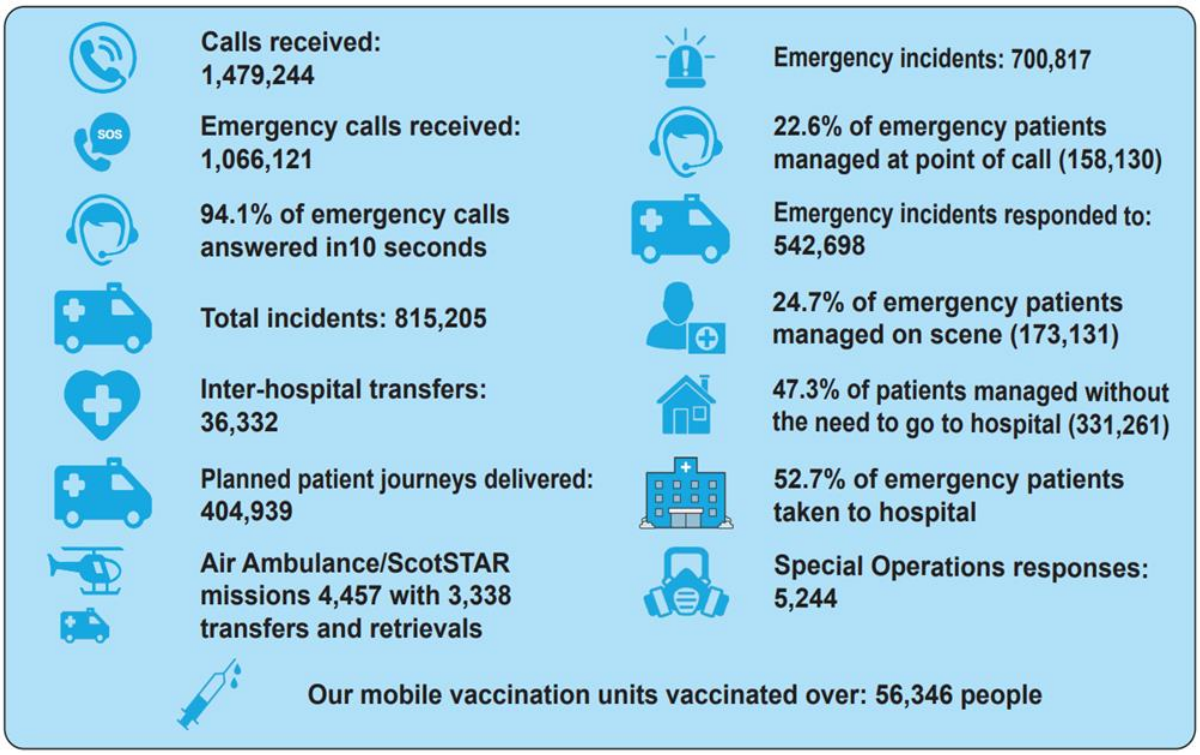
2 About the Scottish Ambulance Service

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 our Ambulance Control Centre handled 1,066,121 Emergency, Urgent and Unscheduled Care calls, up 0.9% on the previous year and responded to over 542,698 Emergency Incidents, 4.2% more than last year. Our Ambulance Control Centre is augmented by teams of multi-disciplinary clinicians (Paramedics, Nurses, Advanced

Practitioners and GP Advisors) within our Integrated Clinical Hub who continue to provide enhanced clinical decision making to ensure patients receive timely and appropriate care that meets their needs.

Last year 22.6% of patients that called 999 were managed without a traditional ambulance response. 158,130 patients were managed by delivering care remotely or by referral to alternative pathways of care. Further information on our activity in 2023-2024 is shown below.



3 Number and Nature of Duty of Candour incidents

Between 1 April 2023 and 31 March 2024, there were 41 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	37
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	4
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 37 out of the 41 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. In the remaining occasions we are reviewing our processes with a view to full compliance in the coming year.

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 Significant Adverse Event 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 Demand and Capacity and Hospital Handover Delays

- Implementation of the SG Guidance: Principles for Safe Transfer to Hospital: Ensuring Timeous Handover of Ambulance Patients. Implementation of actions by NHS Boards is ongoing with communications and local agreed action plans continuing.
- A benefits realisation paper was presented in June 2023 which noted the actions undertaken by the Service to help ease the pressures. The Demand and Capacity programme has recruited a record 1,388 staff over the last three years. The programme has also invested in new vehicles and stations across Scotland, with 52 additional ambulances, ten new locations, and aligned shift patterns to match patient demand more closely.
- We will continue to improve resource availability through the card 46/timed admissions project.
- We have implemented mechanisms and guidance for co-horting care if demand and capacity threshold triggers are met.

Actions relating to our Ambulance Control Centre's (ACCs)

- We have reviewed our operational practice when SAS is unable to contact a patient as part of safety netting practice.
- We are engaging the GP community regarding clinical factors relating to timed 1-hour requests.
- We have reviewed the guidance/standard operating procedures for Call Handlers when dealing with Health Care Professional Welfare Calls to provide clarity about potential delays in response.
- We have explored 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 recirculated the GP booking guide to practices, to help ensure GP's are clear about our booking process and arrangements for upgrading calls.
- We are reviewing our timed admission call back procedures.
- We have reviewed the clinical capacity within the ACC to support incoming calls to ensure the safety netting of waiting calls.
- We are implementing an additional level of safety netting for calls within the Integrated Clinical Hub.
- We have implemented a process for call handlers to share anticipated delay timeframes with callers wherever possible.
- We are reviewing the ACC back to paper process to include all roles within the ACC including Clinical Advisors and the training required for staff.
- We issued a National Bulletin to the Advanced Practitioner (AP) cohort regarding duplicate calls.
- We are reviewing a test of change for autonomous dispatcher deployment of AP resources to lower acuity calls.
- We have provided a range of clinical support initiatives to APs as the Integrated Clinical Hub was embedded in 23/24.
- We are reviewing the escalation process for Clinical Advisors and Advanced Practitioners to ensure there is a means for certain calls to be reviewed for risk and escalated prior to any triage to prevent delay and reduce patient harm.
- We are reviewing the Unable to Triage Process.
- We put in place Continuous Profession Development (CPD) for call handlers to ensure comprehension of Immediately Life Threatening (ILT) situations.
- We are reviewing procurement of an Auto-RES module for our command-and-control system which would enable enhanced resource checking of calls which will minimise risk and ensure an adequate snap shots of resources in a timely manner.
- We are reviewing system triggers for overdose codes.
- We are reviewing the process that highlights to the dispatcher that a call should be allocated if not reviewed by the Clinical Services Desk in 5 minutes.
- We are reviewing staffing levels with the clinical Services Desk to ensure majority of calls passed are addressed within 5 minutes.

- We are reviewing clinical capacity within the ACC to support incoming calls to ensure the safety netting of waiting calls.
- SAS will work to develop guidance, a clear procedure and associated education for SAS call takers and other ACC clinical staff to access translation services in line with the acuity of the call.
- We have developed Scenario / role play CDE for ineffective breathing descriptors to be created and learning shared as part of Call Handler training sessions.
- We re-issued the duplicate call process to all Call Handlers.
- We have reviewed our codes in respect of chest pain calls to identify any codes where higher acuity determinants may apply.
- We are reviewing the possibility for 24/7 staff cover for the Alternative Resources Desk to ensure that Community First Responder coded calls are allocated accurately and timeously.

Actions relating to Staff Education and Training

- We are continuing to create specific learning around dialect, accents and the use of clarifiers.
- We are developing a learning package in relation to the assessment and triage of abdominal pain, incorporating discussion of referral versus discharge of patients.
- We are implementing full Leadership and Management structure for clinicians within Remote Consultation to ensure oversight, training, consistency and safety are achieved at all times.
- We are constructing a continuous improvement plan, in line with an Advanced Practitioner (AP) clinical Lead, to ensure that key learning is planned within AP protected learning time for remote consultation.
- We are reviewing the clinical training provision available for Acute Abdominal Assessment and Hyperventilation Syndrome.
- We re-issued guidance relating to safe non-conveyance and the use of decision support mechanisms.
- We have circulated a Clinical National Bulletin highlighting ‘key learning points’ when using the Corpuls defibrillator.

- Our training and education now includes an increased emphasis on the correct positioning of mechanical CPR devices during training sessions.
- We have issued a staff bulletin to raise awareness of ensuring defib is in 'manual mode' to deploy a shock to a patient.

Actions relating to frontline operations

- We are evaluating the current AP, Paramedic Response Unit and single responder test of change to implement any recommendations.
- We are reviewing the assessment and decision making surrounding the patient's method of extraction from house to the Ambulance.
- We are changing the dispatch rule for Wildcat GoodSAM responders to ensure C3 triggers a GoodSAM alert even without a specified patient age.
- We are exploring options for the addition of an audible alert to the defibrillator, to confirm the press to shock button has been pressed correctly.
- We have reviewed the resilience of our ScotSTAR vehicles and equipment.
- We have reviewed the thermometers used within Neonatal Transport to ensure they mirror those used in referring/receiving sites.
- The thermoregulation guideline for Neonatal Transport was shared across all teams.
- We reviewed the induction and training within Neonatal Transport.
- We applied a Defibrillator software update.
- We now enable Police Scotland officers to be in direct contact with SAS from the scene of incidents, providing first hand current information allowing SAS to triage more accurately with additional education provided to the Police.
- The Health Care Professional (HCPs) booking guide was reviewed by our Associate Medical Director and reissued to all HCP's.

Actions relating to Clinical Guidelines

- We will develop guidance with the Prison Service, outlining appropriate SAS response to medical support on prison sites, detailing considerations for in and out of hours care, prisoner healthcare rights and escalation for additional advice.

- We will highlight to ambulance clinicians' escalation routes/ support for challenging patient incidents/refusals of care.
- We will review and update the SAS Documentation Standards Guideline to include criteria for audit and feedback processes, identifying some key areas for routine consideration of practice standards, such as ePR documentation compliance and non-conveyance.
- We will update the non-conveyance page on the electronic patient record to include key mandatory fields that will support improved quality and compliance with documentation standards.
- We are reviewing the newly drafted triage guideline for review by the ScotSTAR Clinical Standards Group.
- We are continually reviewing the ScotSTAR Guideline 017 Respiratory Viral Infection Risk Assessment and Management and ensuring changes are appropriately communicated and understood by operations.
- We are ensuring that SAS Infection and Prevention and Control (IPC) recommendations are included in air ambulance re-procurement requirements and that SAS IPC are represented during evaluation of contractor proposals.
- We are reviewing and aligning the deployment of Standard Operating Procedures and the Pre-Determined Attendance for APs, Paramedic Response Units and Single Responders.

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.