Scottish Ambulance Service
University National NHS Board

NHS SCOTLAND

Freedom of Information Request

3rd December 2024

Question

Please provide a copy of all SAER reports completed in 2022, 2023 and 2024 to date. I understand any patient or staff names will be redacted.

Answer

We consider your request for a copy of all SAER reports completed in 2022, 2023 and 2024 to be exempt from disclosure under the Freedom of Information Scotland Act (FOISA)2002. To help explain, the following exemptions have been considered and applied

A SAER is made up of a collection of documents, containing for example information about, a patient, a deceased patient, staff, and various third parties. All context of this information relates to the patient/deceased patient, staff involved and third-party involvement.

Section 38(1)(b) of FOISA, information is exempt from disclosure if the information is personal data, and its disclosure would breach one or more of the data protection principles contained in the DPA. We consider the specific detail contained within the reports, there is a high likelihood patients could be identified, which in turn increases the likelihood of patients' relatives, staff involved and third-party identification to be identified. This is an absolute exemption and not subject to the public interest test.

Section 28 (1)(d) of FOISA, information is exempt from disclosure if it constitutes a deceased persons health record. A number of SAERS are prepared following the death of a patient. Meaning information contained and reviewed as part of the collection of documents are from a deceased persons health records and these are considered exempt from disclosure.

The review of SAERs is a key part of SAS' Clinical Governance Framework. In 2023 we reviewed our governance and assurance processes and set up the Patient Safety & Clinical Risk Group, which has membership from managers and front-line clinicians across the Service. The group provides monitoring and oversight of adverse events across the Service so that we can learn from events. Learning from such reviews contributes to valuable improvements in patient safety and experience, and we recognise the impact this also has on our staff. Learning from adverse events also help us optimise our response and enable our clinicians to deliver the best possible care. Details of reviews and associated actions are shared with our Clinical Governance Committee, as well as details of family / carer engagement and involvement.

We publish our annual Duty of Candour report, which provides additional information, into the public domain. A copy of which can be found at our publications section of our Website: Reports