

Spire Edinburgh Hospitals

Duty of Candour Annual Report Template

Every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Services must tell the patient, apologise, offer appropriate remedy or support and fully explain the effects to the patient.

As part of Spire Edinburgh Hospitals' responsibilities, we must produce an annual report to provide a summary of the number of times we have triggered a Duty of Candour within our service.

Name & address of service:	Spire Edinburgh Hospitals (part of Spire Healthcare Limited) 122 Corstorphine Road Edinburgh EH12 6UD	
Date of report:	12 th May 2021 <i>Data provided is for period 1st January 2020 to 31st December 2020</i>	
How have you made sure that you (and your staff) understand your responsibilities relating to the duty of candour and have systems in place to respond effectively? How have you done this?	<p>Yes</p> <p>Spire Healthcare implemented their <i>Duty of Candour</i> policy in 2017 in line with the statutory duty under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as amended ("Duty of Candour") to act in an open and transparent way with patients in relation to their care and treatment. The Spire Duty of Candour policy was last updated September 2020.</p> <p>This was cascaded to staff and teaching sessions conducted at this time. When the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (The Act) and The Duty of Candour Procedure (Scotland) Regulations 2018 (the Regulations) set out a new Duty of Candour staff were updated. In addition – we provide teaching sessions to newly inducted staff and consultants as well as ongoing reorientation sessions to existing staff and consultants.</p>	
Do you have a Duty of Candour Policy or written duty of candour procedure?	YES	

How many times have you/your service implemented the statutory duty of candour procedure this financial year?

Spire Murrayfield Hospital – 8 occasions

Spire Shawfair Park Hospital – 3 occasions



Type of unexpected or unintended incidents (not relating to the natural course of someone's illness or underlying conditions)	Number of times this has happened from 1 st January 2020 to 31 st December 2020
A person died	No
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	No
A person's treatment increased	Spire Murrayfield Hospital – 8 occasions Spire Shawfair Park Hospital – 3 occasions
The structure of a person's body changed	No
A person's life expectancy shortened	No
A person's sensory, motor or intellectual functions was impaired for 28 days or more	No
A person experienced pain or psychological harm for 28 days or more	No
A person needed health treatment in order to prevent them dying	No
A person needing health treatment in order to prevent other injuries as listed above	No
Total	11 occasions

Did the responsible person for triggering duty of candour appropriately follow the procedure? If not, did this result in any under or over reporting of duty of candour?	Yes
What lessons did you learn?	That an apology to the patient does not necessarily imply we have done something wrong but is the correct course of action if a patient's treatment has increased as a result of the incident.
What learning & improvements have been put in place as a result?	Ongoing monitoring of these incidents to ensure compliance with Spire's policy, The Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (The Act) and The Duty of Candour Procedure (Scotland) Regulations 2018.
Did this result in a change / update to your duty of candour policy / procedure?	No
How did you share lessons learned and who with?	We share learnings through safety bulletins, safety huddles, daily discussions as well as clinical effectiveness and clinical governance.



Could any further improvements be made?	Ongoing training and coaching to increase staff awareness and confidence to be empowered to complete DOC process.
What systems do you have in place to support staff to provide an apology in a person-centred way and how do you support staff to enable them to do this?	Guidance and templates are included in Spire Healthcare's Duty of Candour policy. In addition, we provide coaching, support, learnings from our reporting system and documented escalation mechanisms.
What support do you have available for people involved in invoking the procedure and those who might be affected?	An open culture and to ensure the reporting of events as either statutory or profession DOC
Please note anything else that you feel may be applicable to report.	Nil