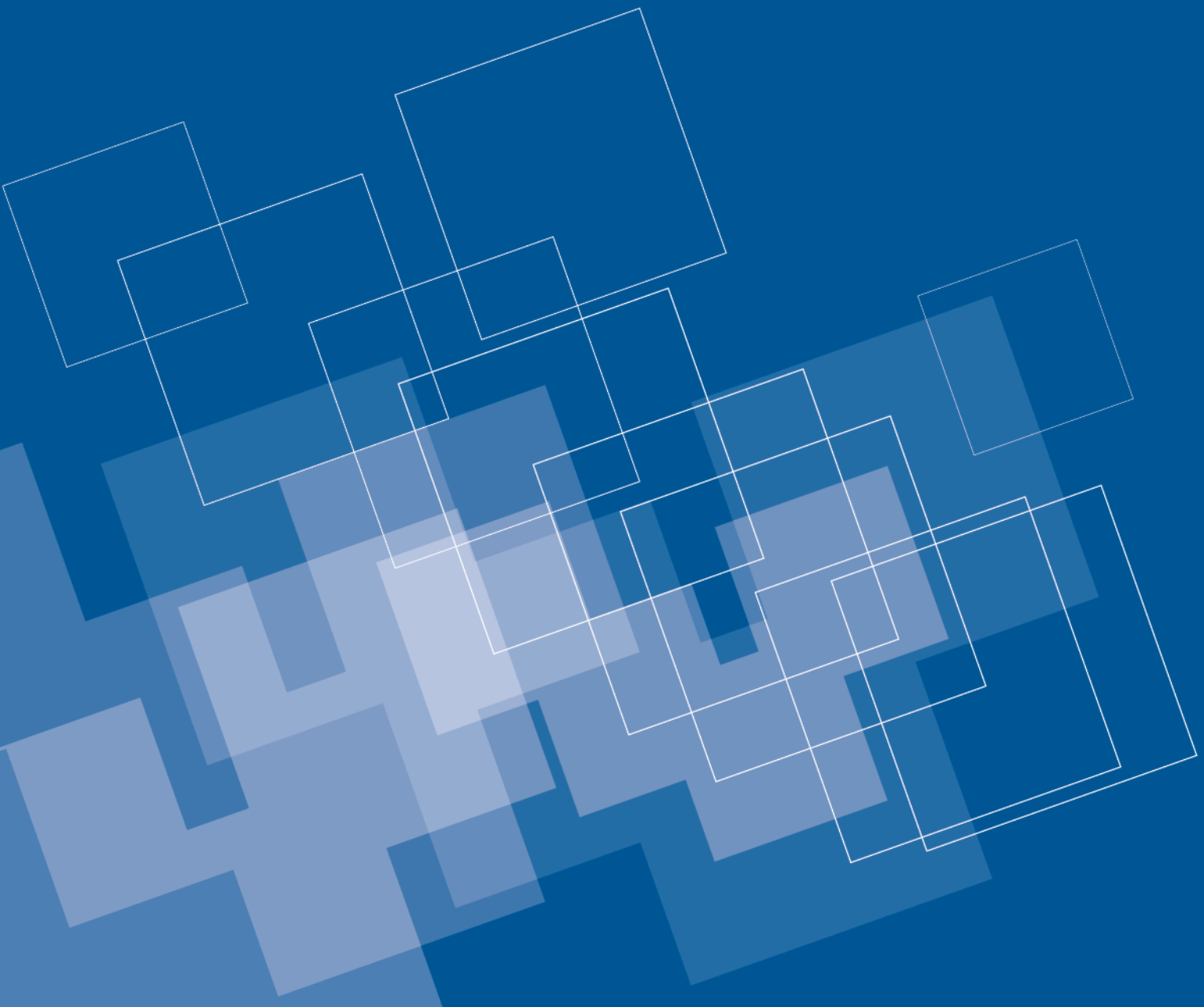
East Lothian Council

CHILDREN'S SERVICES
DUTY OF CANDOUR ANNUAL REPORT

1st April 2021 to 31st March 2022



Duty of Candour Annual Report

East Lothian Council Children's Services

Social care services for children

All health and social care services in Scotland have a legal duty to be open and honest when unintended or unexpected events happen while providing health or social care services, and where death or harm results. The people affected should understand what has happened, receive an apology, and know that organisations learn how to improve for the future.

A registered health professional who was not involved in the incident must reasonably have concluded that the events resulted in death or harm. The specific details of the duty of candour, and definition of "harm" are contained in the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016.

This short report describes how East Lothian Council Children's Services has operated the duty of candour during the time between 1 April 2021 and 31 March 2022.

About East Lothian Council

East Lothian Council serves a population of 104,840 people across East Lothian (estimate for 2017). Under 18s make up 21.4% of the population. We cover a diverse geographical area, including large and small towns as well as rural areas.

Children's Services has responsibility for children and young people in need of care and protection within this area. It has various duties to carry out by law, in relation to these children. Some duties apply to some young people up to the age of 25.

How many incidents happened to which the duty of candour applies?

Between 1 April 2021 and 31 March 2022, there were **no incidents** where the duty of candour applied. (These are unintended or unexpected incidents that result in death or harm as defined in the Act, and do not relate directory to the natural course of someone's illness or underlying condition.)

Through the adverse event process, we determine if there are factors that may have caused or contributed to an event, which helps to identify duty of candour incidents.

Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition)	**Number of times this happened (between 1 April 2021 and 31 March 2022)**
A person died	0
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A person's treatment increased	0
The structure of a person's body changed	0
A person's life expectancy shortened	0
A person's sensory, motor or intellectual functions was impaired for 28 days or more	0
A person experienced pain or psychological harm for 28 days or more	0
A person needed health treatment in order to prevent them dying	0
A person needing health treatment in order to prevent other injuries as listed above	0
Total	0

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?	Not Applicable (NA)
What lessons did we learn?	NA
What learning & improvements have been put in place as a result?	NA
Did this result in a change / update to our duty of candour policy / procedure?	NA
How did we share lessons learned and who with?	NA
Could any further improvements be made?	NA
What systems do we 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?	We have not had any incidents or issues that have involved duty of candour. All staff receive mandatory training on duty of candour. Our reporting system picks up if any incidents are reportable and this cascades into our quality governance reporting. DoC is part of our overall approach to managing incidents. In the event of any incidents staff would be supported by a senior manager and all apologies would be offered verbally and in person and ideally involve the staff member, if appropriate.
What support do you have available for people involved in invoking the procedure and those who might be affected?	NA
Anything else that may be applicable to report.	NA

3. Other information

As required, East Lothian has submitted this report to the Care Inspectorate and we have also placed it on our website and the intranet. In addition, the CSWO has made reference to Duty of Candour data in the annual CSWO report, with information being taken from the Duty of Candour annual report.

If you would like further information regarding this report, please contact:

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