

Comhairle nan Eilean Siar

Duty of Candour Annual Report

For the Financial Year 1 April 2021 to 31 March 2022

(Part 2 of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016)

All providers of health, care and social work services in Scotland have a duty of candour. 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 and receive an apology, and organisations learn how to improve for the future.

The Comhairle's Duty of Candour Policy Statement & Procedural Guidance is published on our website at https://www.cne-siar.gov.uk/social-care-and-health/community-care-and-criminal-justice/duty-of-candour/.

An important part of the duty is that we provide an annual report about how the Comhairle has applied the duty of candour during the financial year. We hope you find this report useful.

1. About the Comhairle's Services

As a local authority, the Comhairle provides care and social work services in fulfilment of its statutory obligations. Those services cover a wide range of areas including home care, residential care, housing support, and adult and child social work services.

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

In this financial year, there were no incidents where the duty of candour applied.

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	Number of times this happened in the financial
(not related to the natural course of	year
someone's illness or underlying condition)	
A person died	0
A person incurred permanent lessening of	0
bodily, sensory, motor, physiologic or	
intellectual functions	
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	0
functions was impaired for 28 days or more	
A person experienced pain or psychological	0
harm for 28 days or more	
A person needed health treatment in order to	0
prevent them dying	
A person needing health treatment in order	0
to prevent other injuries as listed above	
Total	0
To what extent did the Comhairle, as the	Not Applicable (NA)
responsible person under the Act,	
appropriately carry out the duty and follow	
the procedure?	
Did this result in any under- or over-reporting	
of incidents as activating the duty?	
What lessons did we learn?	NA

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What learning & improvements have been	NA
put in place as a result?	
Did this result in a change or update to our	NA
duty of candour policy and guidance?	
How did we share lessons learned and with whom?	NA
Could any further improvements be made?	NA
What systems do we have in place to support staff to provide an apology in a personcentred way and how do we support staff to enable them to do this?	All staff receive mandatory training on the duty of candour, which is part of our overall approach to managing incidents. The Policy Statement & Procedural Guidance sets out our process for applying the duty.
What support do we 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, the Comhairle has submitted this report to the Care Inspectorate and we have published it on our website.

If you would like further information regarding this report, please contact the Monitoring Officer, whose responsibility it is to compile the report:

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