



Duty of Candour

Annual Report 2024 – 2025

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1 Duty of Candour Report

Duty of Candour is a legal requirement of all health and social care services in Scotland. It ensures that if something goes wrong in a service the people affected are offered an explanation, an apology and an assurance that staff and the organisation will learn from the error. The learning is shared with the people affected and throughout Scotland.

All health and social care services in Scotland must provide an annual duty of candour report for their service. As a social care provider this information is sent to our regulator the Care Inspectorate.

2 About our organisation

Enable Scotland (Leading the Way) is the leading Scottish charitable organisation for people with learning disabilities and their families. The organisation has distinct activities of:

- delivering personalised support services to enable customers to live a life which makes sense to them and to achieve their goals.
- delivering personalised employability services to enable customers to live a life which makes sense to them and achieve their goals.
- fundraising and campaigning to enable work to challenge negative attitudes to people with learning disabilities.

The organisation provides social care support to approximately 1000 people across Scotland who either live in their own homes or share with a small number of others. All direct support staff are matched to work for either an individual person or a small number of people.

The organisation has a Duty of Candour policy and staff guidance. All staff with line management responsibility complete training about the requirements of Duty of Candour. It also forms part of our induction programme.

3 Our Policy and Process

The organisation's internal reporting process for accidents and incidents will initially capture information about any events which require the implementation of the Duty of Candour procedure. The Manager who oversees the service is informed about the incident promptly, the Care Inspectorate is notified through e-forms and reports made to local authority and health teams involved in the person we support's care. Senior Managers are also informed of such incidents. A prompt apology would be issued to the person supported or another appropriate person (i.e. next of kin, Guardian, or Attorney) and immediate steps taken to avoid a reoccurrence.

The resulting investigation of the incident will aim to highlight any learning done and any improvements/changes required to practice, policy and/or process. Any learning taken from the investigation of an incident will be shared across the organisation to minimise the risk of further occurrence and improve the service we deliver.

Staff affected by the incident will receive support from line managers and can also access an external, confidential 24hr hour employee assistance service.

Whilst the focus of the investigation will be about learning and improving as opposed to apportioning blame where an incident occurs because of wrongdoing by staff the organisation's Disciplinary Process will be implemented.

This Annual Report is an item for our Trustees to discuss at their Board meeting and is included in our Risk Register monitoring.

4 Incident Report

During the reporting period 1st April 2024 to 31st March 2025 there have been no incidents triggering the duty of candour.

Type of unexpected or unintended incident	Number of times this happened
Someone has died	0
Someone has permanently less bodily, sensory, motor, physiological or intellectual function	0
Someone's treatment has increased because of harm	0
The structure of someone's body changes because of harm	0
Someone's life expectancy becomes shorter because of harm	0
Someone's sensory, motor or intellectual functions is impaired for 28 days or more	0
Someone experienced pain or psychological harm for 28 days or more	0
A person needed health treatment to prevent them dying	0
A person needing health treatment to prevent other injuries	0
Total	0

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