Duty of Candour Report – 01st April 2025 – 31st March 2026

Duty of Candour

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

About our organisation

Teens+ is a transitional service that offers educational support to adults who have a learning disability, additional support need, Autistic spectrum diagnosis, complex behavioural and communication needs.

We provide support to people within our education centres as well as in the community.

At the time of writing this report Teens+ provides support to 125 students.

Teens+ delivers personalised education support that is captured within an 'Individual learning plan' this is agreed with the student and based on their learning outcomes.

The support is delivered by highly trained professional staff teams who are matched with the students to form a personalised education experience.

Teens+ is part of the Capella charity and we have a very clear vision and values for everyone that receives our support.

Duty of Candour Report – 01st April 2025 – 31st March 2026

Teens+ has a Duty of Candour policy and staff guidance. All staff undertake training to help them understand the Organisation's policy and the process of the Duty of Candour which could affect them.

The students that we work with have a varied knowledge and differing experiences of education. The majority of our students have the requirement for individualised support tailored to them due to their learning and educational needs.

Incident Reporting

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

During the reporting period we have had 1 incidents that triggered the Duty of Candour.

Type of unexpected or unintended incident	Number of times this happened
Someone has died	0
Someone has permanently lost bodily, sensory, motor physiologic or intellectual functions	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 in order to prevent them dying	0

Duty of Candour Report – 01st April 2025 – 31st March 2026

A person needing health treatment in order to prevent other injuries	0
Other unexpected or unintended incident that we have treated under the Duty of Candour guidance	1

Procedure

In the case of the incident the correct procedure was followed;

- We informed the people affected, apologised to them and arranged to meet with them.
- Internally senior staff reflected on the events, identified what had happened and gone wrong and what we had learnt and could have done differently or better.
- This information was shared with all our staff through our team meetings, debriefing meeting to go over the incident and addressed through on-going support, supervision and development.
- The incidents formed part of the reporting process to the Board.
- An internal and external investigation was completed into the incident that occurred.

The incident were discussed with the student involved and their family.

We recognise that the incidents that we have supported under Duty of Candour may not meet the full requirements due to the lower severity of the incident, however we feel it was an appropriate course of action to support and respond in line with this Policy.

Our Policy and Process

When an incident occurs that necessitates the implementation of Duty of Candour, our staff reports this to their line manager and to the Head of Service who oversees the service we provide. The incident is recorded and the Head of Service completes the Care Inspectorate reporting e-form. This is then followed up with a phone call to the Inspector if needed. The Head of Service then reports the incident to the Commissioning local authority or Social Care Direct should this be required.

The internal Incident form highlights the learning needed or actions required as a result of the incident and any further development needs for the individual or the team.

Duty of Candour Report – 01st April 2025 – 31st March 2026

Our external confidential, employee support helpline service is available to all our staff at any time but if a Duty of Candour is triggered it is emphasised to staff that this is available.

A line manager, senior manger or Head of HR will meet with the staff member to provide support and emphasise this is about learning and improving not blame.

Duty of Candour is part of our Core training which all staff have to undertake, in addition to the legislation a series of scenarios form part of the training to emphasise to staff what while it is distressing when things go wrong, we can and do learn from our mistakes and adapt our processes to try and minimise the events recurring. This is also included in our Whistleblowing policy and values training that we provide through every staff Induction.

Where the incident arises from staff wrong doing our disciplinary process is immediately put in place.

What have we learned?

In this reporting year for Duty of Candour incidents we have learned –

- The support our staff needed to understand Duty of Candour and the processes that need to be undertaken
- How communication needs to be immediate, precise and transparent with any action required
- Understanding the need of observing and monitoring the students at all times
- How to report directly to families and work collaboratively when an incident occurs
- How to risk assess behaviours that were unknown at the time of the incident
- How to implement processes quickly but carefully when an incident has been presented
- How to Risk assess confidently and share this across the required parties internally and externally
- How to debrief after an incident to ensure appropriate learning is captured immediately

If you would like further information about this report, please contact us using these details;

Simon Pearce-Madge – Head of Service

simon.pearcemadge@teensplus.org.uk