



THE LIVEWELL SYNDICATE · POLICY

Duty of candour *statement.*

Our commitment to be open and honest with you when something goes wrong.

The Livewell Syndicate Ltd

Unit L3, Base Business Space, Chamberlain Road, Hull, HU8 8HL, East Yorkshire, UK
(01482) 765 131 · hello@livewellsyndicate.com · www.livewellsyndicate.com

TYPE	REF	VERSION	DATE	REVIEW
Statement	CG-05	5.1	03/10/2026	30/09/2027

Knowledge gives you control over your health.

Controlled document

Document control.

ITEM	DETAIL
Policy code	CG-05
Title	Duty of candour statement.
Purpose	Sets out how The Livewell Syndicate is open and honest with clients when something goes wrong with their care, and what it does when a notifiable safety incident occurs.
Applies to	All staff of The Livewell Syndicate, and anyone acting on its behalf, including sample collection practitioners.
Owner	Daniel Snow, Managing Director.
Authorised by	Cynferth J. Turrian, Executive Director and Clinic Manager. Date: 03/10/2026
Approved by	Daniel Snow, Managing Director. Date: 03/10/2026
Version	5.1
Date issued	3 October 2026
Next review	30 September 2027, or sooner if practice, law or circumstances change. Review carried out by Daniel Snow.
Law and guidance checked	3 October 2026

Amendment record

DATE	SUMMARY
3 October 2026	Version 5.1, issued 3 October 2026.

Related documents: CG-03 Complaints, Compliments and Feedback Policy; CG-08 Significant Event Analysis (SEA) Policy; HS-01 Accident and Incident Reporting Policy; CC-08 Results Communication Policy; SG-02 Safeguarding Policy; IG-03 Information Governance and Data Protection Policy.

Our commitment.

1. When something goes wrong with a client's care, The Livewell Syndicate tells them, explains what happened, apologises and puts it right where it can. It does not wait for a complaint, and it does not wait to be asked.
2. The Livewell Syndicate is not yet registered with the Care Quality Commission, so Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 does not yet bind it in law. It follows Regulation 20 now, by choice, and will be bound by it once registered.
3. Registered health professionals who work with or for The Livewell Syndicate, such as nurses employed by its partners, also have their own professional duty of candour, set by their regulators, including the General Medical Council and the Nursing and Midwifery Council.

What this covers.

4. Every mistake that affects a client. A lost sample, a delayed result, an error in a report or a result sent to the wrong person: the client is told promptly and honestly, whatever the level of harm.
5. Notifiable safety incidents. The Livewell Syndicate uses the definition in Regulation 20(9), which applies to providers that are not NHS bodies: an unintended or unexpected incident during the client's care that, in the reasonable opinion of a health care professional, appears to have resulted in, or needs treatment to prevent:
 - the death of the client, where the death relates directly to the incident rather than to the natural course of an illness;
 - an impairment of sensory, motor or intellectual functions lasting, or likely to last, at least 28 days in a row;
 - changes to the structure of the body;
 - prolonged pain or prolonged psychological harm, lasting at least 28 days in a row; or
 - a shortening of life expectancy.
6. Examples in this service could include a nerve injury during a blood draw that lasts 28 days or more, or harm caused because a critical result was not acted on in time.

What we do after a notifiable safety incident.

7. Tell the client, or someone acting for them, as soon as reasonably practicable after the incident is identified. This is done in person where possible, or otherwise by video or telephone.
8. Give a truthful account of everything known at that point, explain what further enquiries will be made, and apologise. An apology is not an admission of liability (Compensation Act 2006, section 2).
9. Offer reasonable support, such as a repeat test at no cost, or help to access NHS care.
10. Follow up in writing with the same information, then write again with the results of the enquiries once they are known.
11. Keep a secure written record of every notification, every step taken and the outcome. If the client cannot be reached, or does not want to be involved, the attempts and their wishes are recorded.

Who is responsible.

12. The Managing Director owns this statement, decides whether an incident is notifiable, and makes sure every step is carried out.
13. The Clinic Manager makes sure incidents are reported and recorded.
14. Every member of staff reports anything that has gone wrong, or nearly gone wrong, straight away. Nobody is penalised for reporting honestly.
15. Partners, including the laboratory and the results platform, tell The Livewell Syndicate promptly about any incident affecting its clients, so that the client receives one coordinated and honest account.

Learning.

16. Every incident is reported under the Accident and Incident Reporting Policy (HS-01) and reviewed under the Significant Event Analysis (SEA) Policy (CG-08). Every notifiable safety incident is also reviewed at the quarterly governance review, so that it does not happen again.
17. Where a client has also complained, the Complaints, Compliments and Feedback Policy (CG-03) applies as well. The duty of candour applies whether or not a complaint has been made.
18. This statement is reviewed every year.

Tell us if you think something has gone wrong.

19. Email complaints@livewellsyndicate.com or call 01482 765 131.

Law and guidance.

Care Quality Commission. (2022). Regulation 20: Duty of candour. Newcastle upon Tyne: CQC.

Compensation Act 2006, section 2.

General Medical Council and Nursing and Midwifery Council. (2022). Openness and honesty when things go wrong: The professional duty of candour. London: GMC and NMC.

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 20.