THE HARMED PATIENT PATHWAY

What is it?

The Harmed Patient/Family Care Pathway is a project involving various stakeholders in identifying the needs that are created by being affected by healthcare harm and the support and types of responses required for meeting those needs. The Pathway will consist of a range of responses and support that anyone affected by harm in healthcare should be able to expect is available from (or paid for by) their care provider, (or the NHS centrally).

It is based on the principle that NHS providers have a moral duty of care to people affected by healthcare harm and that a just and restorative response aimed at meeting the needs that emerge for them is necessary. Our hope is that the Pathway of care and support that we co-design will become official guidance and/or standards for the NHS and ensure a consistent and holistic response to those affected by healthcare harm.

What led to the project?

The project was launched by the charity Action against Medical Accidents (AvMA) and the Harmed Patients Alliance (HPA) in February 2021. AvMA has 40 years' experience of supporting and advising people affected by avoidable harm in healthcare and working with them to ensure they are dealt with fairly and patient safety is improved. HPA was founded by people with direct lived experience with the aim of increasing understanding of the needs that emerge after healthcare harm and the more restorative healing and caring response needed to meet them.

Our experience and that of our beneficiaries / members with whom we engage is that care and support available is inconsistent across the NHS when harm has occurred. Too often, those most affected are seen as just witnesses and at best recipients of reports from investigations, rather than people in need of care and support to enable their recovery. This can lead to 'second harm' caused by failing to meet the needs of those affected, on top of the primary harm caused by the incident. This creates untold additional suffering, additional cost to the NHS / society, lost opportunities to learn and improve; and conflict resulting in complaints processes and litigation.

What will the project do?

The Advisory Group for the project has already produced a list of the kinds of support and involvement that anyone suffering from healthcare harm should be able to expect. . This is being made available to NHS trusts who want to participate in the project together with a set of questions to aid their own self-assessment / gap analysis. Participating Trusts will then use their gap analysis to create a workplan to address the areas they feel weak in. A certain amount of free advice and information will be available from the project advisory group and fellow participating trusts. We can also advise you of relevant training and consultancy, if needed. The results of this work will be analysed when the project has received enough feedback and a report will be produced recommending what a national Harmed Patient Pathway should look like. It is hoped that this concept will be taken up by bodies such as NHS England/Improvement and the CQC and form part of their standards and guidance.

Why should your Trust get involved?

Firstly, because you care about those who have been affected by harm under your care. You will be assisted in improving how you support them in your own trust and you will also be helping develop a more appropriate and consistent approach nationally. Your work on this may assist you in assuring the CQC that you are meeting their standards, and NHS England that you are implementing the new Patient Safety Incident Response Framework appropriately. Your trust could also save money from

not having to treat people who are caused ‘second harm’ and avoid costly and time-consuming complaints and litigation.

Who is overseeing the project?

The Advisory Group for the project currently consists of: Peter Walsh, Action against Medical Accidents (AvMA); Joanne Hughes, Harmed Patient Alliance; James Titcombe OBE, Harmed Patient Alliance; Maggie Davies, Sussex Hospitals NHS Trust & trustee of AvMA; Lou Pye, Healthcare Safety Investigation Branch (HSIB); Kate Jarman, Milton Keynes University Hospitals NHS Trust; Rosi Reed, Making Families Count

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