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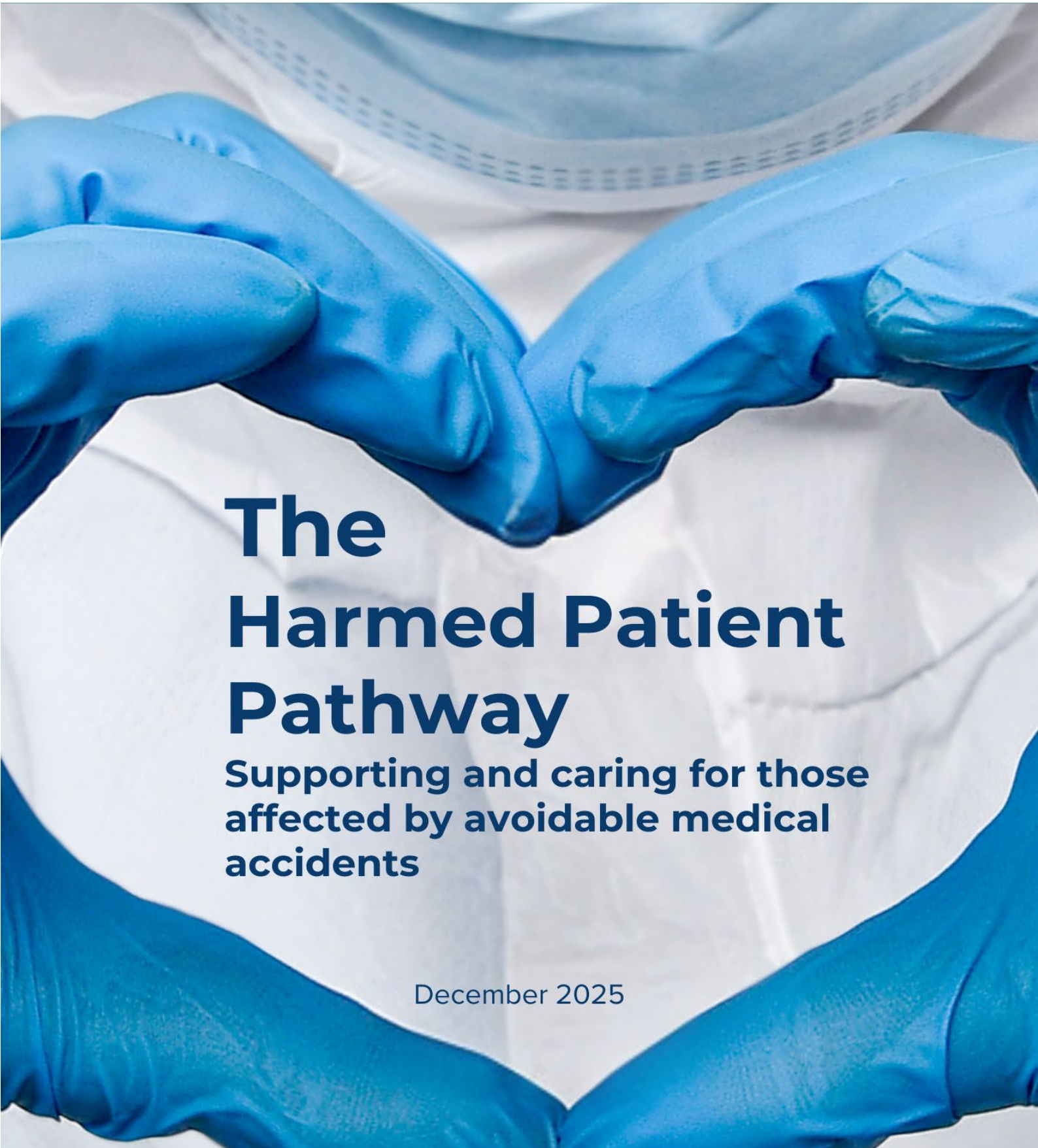

The Harmed Patient Pathway

Supporting and caring for those affected by avoidable medical accidents

December 2025

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Contents

Acknowledgements

AvMA and the Harmed Patient Alliance (HPA) would like to acknowledge all the harmed patients and their families who have shown strength and determination in sharing their experiences of responses to harm when things go wrong in healthcare, and the impacts those responses have had on them and their lives. These powerful testimonies of further harm caused from responses that haven't prioritised harmed patient wellbeing, have been the driving force in our work developing the Harmed Patient Pathway, which we hope will materially improve how harmed patients and families' needs are understood and attended to when harm occurs.

We wish to acknowledge the contribution of Joanne Hughes, who co-founded HPA with James Titcombe and proposed the need for a care pathway encouraging recognition of harmed patients and families as people to whom a duty of care is owed by the NHS and those representing it, to do no more harm and help to heal. Joanne's knowledge of Restorative Justice philosophy, principles, and practices and their relevance for helping to avoid compounded harm and support healing has been invaluable.

We wish to recognise the significant contributions and invaluable expertise of our advisory group members: Paul Whiteing, Eleanor Riches, James Titcombe, Caroline Browne, Louise Pye, Rosi Reed and Peter Walsh MBE. We also wish to recognise the contribution of Linda Kenward.

We are grateful for the insights and contributions shared by a number of NHS trusts in the early days of development as well as all of the individuals, healthcare bodies and regulators who generously shared their thoughts and suggestions during our extensive consultation on the draft commitments that underpin the Pathway.

Introduction

Healthcare providers – which for most people in the UK is the NHS - exist to support the health and wellbeing of their patients, through the provision of safe, effective and person-centred care.

When a patient is harmed by the healthcare they receive, we believe that core purpose should remain unchanged. Healthcare providers have a moral duty of care to the harmed patient and their family, to attend to what they need to be able to heal and recover from their experience to the extent possible, and especially to do no more harm.

This is precisely why we have developed the Harmed Patient Pathway. It has been designed to help healthcare providers respond compassionately to patients and families' needs when there has been harm. It sets out the most important things that are required to support their healing journey and avoid the possibility of "second" or "compounded" harm.

The Harmed Patient Pathway includes the Restorative Learning approach advocated within the Patient Safety Incident Response Framework (PSIRF) compassionate engagement and involvement guidance. It also includes the intent of the Duty of Candour – to be honest with patients and families if care goes wrong and sincerely apologise. However, it applies whether or not there is a Patient Safety Incident Investigation or review, and no matter what the level of harm is. It recognises that disclosure and learning are essential but not always enough after harm has occurred. The Harmed Patient Pathway is driven firstly by a commitment to respond to the experience of harm and the range of healing needs the patient and their family may have. System safety improvement and compliance with statutory duties will likely be enhanced by the Pathway - but they are not its primary focus.

There are three core concepts that underpin the Harmed Patient Pathway and the Commitments:

- That providers of healthcare owe a moral duty of care to patients and families who have been harmed, to do no more harm and support their recovery as much as is possible.
- That patients and families who have been harmed, will have been impacted as a result. Those impacts create needs that require a moral and just response from the staff and organisation where the harm happened. Striving to meet their needs is essential for them to heal or recover and avoid second or compounded harm. The term "pathway" is used to make the analogy with clinical care pathways that are designed to enable safe, effective, and individualised care for any patient with a particular diagnosis. In this pathway the diagnosis is 'healthcare harm'
- That meeting the needs of harmed patients/families and avoiding second or compounded harm is an essential part of any genuine "just" and "restorative" patient safety culture".

Development of the Harmed Patient Pathway has been co-led by AvMA (Action against Medical Accidents) and the Harmed Patients Alliance (HPA) and is informed

by the testimonies of patients and families over decades, along with incorporating the extensive feedback received from patients and professionals alike from our public consultation in December 2024.

How to use the Harmed Patient Pathway

It is our wish that those seeking to use the Pathway documents to support improvements in harm responses do so from a place of genuine commitment to making harmed patient and family wellbeing a firm priority. We ask that everyone does that which they are able, whether it is at policy, process, or personal practice level, to enable the commitments the Pathway requires to be realised.

The Pathway consists of six core commitments that organisations are asked to make, with an explanation of why each commitment is necessary from a healing perspective, together with the actions which may be necessary (depending on individual patient/family needs) to honour each commitment.

The commitments are not a “checklist” to be ticked off. Rather they represent a cultural mind-set in how to think about and practically respond to the healing needs that result from harm, for patients and their families, as well as staff who we recognise as being impacted by harm events.

There needs to be organisational buy-in to the commitments and a genuine *intention* to be able to deliver the required actions. We understand that it may not be possible to deliver on all of the actions the Pathway suggests from day one. We encourage organisations and individuals at all levels of the system to use this first publication of the Pathway to self-assess policies and practice, and work to improve where possible.

Organisations can also consider what external help would be beneficial in objectively assessing how well they are living up to the commitments, and they should include harmed patients and families in that process. They may also need to invest in capability and capacity to deliver the commitments across their organisation, via training and implementation support where needed.

If you would like to discuss the Harmed Patient Pathway with AvMA and HPA, – for any reason, including for more information, some advice or for implementation support, then please contact us at: hpp@avma.org.uk

Commitment 1

We ensure compassionate and honest communication with harmed patients and their families that supports dignity, trust and just relations.

Why?

A sincere commitment to implementing the Duty of Candour in the spirit it was intended requires being honest, giving clear, timely explanations and making meaningful apologies that are all essential for restoring dignity and wellbeing and maintaining just relations These are also key factors in re-establishing trust that has been damaged. For apologies to be meaningful, they need to be made with compassion: those apologising must show they are conscious of the person's distress and need to make sense of what happened to them, and they must want to alleviate that distress. Meaningful apologies include acknowledgement of responsibility for harms caused, genuine regret and the facilitation of dialogue aimed at agreeing and committing to actions that support healing and learning.

	Essential elements of Commitment 1
1a	Communications with harmed patients/families are compassionate and dignifying. They are listened to and their explanation of what happened acknowledged. Any written communication should be bespoke to the detail of the situation (generic letters are not meaningful and do not constitute an apology)
1b	Communications with harmed patients/families are timely, open, honest, respectful and transparent. Communication should take account of the differing cultural needs of patients/families. Patients have a key point of contact for the duration of any investigation-related matters.
1c	Explanations for the cause of harm are as full and clear as possible to meet the needs of the patients/families and aid their understanding.
1d	Acknowledgement of the harm caused is made in an honest and open manner.
1e	Apologies are sincere, and meaningful to patients/families by being personalised and responsive to their needs. Where an incident has generated additional learning, assurances are provided that changes will be made as a result

Commitment 2

We ensure that harmed patients/families get the support they need as far as possible and we assist them with access to specialist independent advice and support in order to support their wellbeing.

Why?

People affected by harm in healthcare are often traumatised and have little or no knowledge of the processes that organisations must follow or what they themselves should do next. Their trust in the organisation may be damaged. They may have emotional or psychological needs as well as a need for practical advice or advocacy; they may experience compounded (or a second) harm if these needs are not met. Some of these needs can be fulfilled by the organisation itself or the NHS, but other needs may be best met by bodies entirely independent of the organisation where the harm occurred, provided by experts with the relevant specialist knowledge and experience. This can help patients/families take part in processes, such as investigations or reviews, in a meaningful way and get the outcomes they seek. It can also benefit the organisation by improving the quality of investigations/reviews and avoiding unnecessary litigation costs or protracted complaints.

	Essential elements of Commitment 2
2a	We communicate with patients/families to understand the impact the harm has had on them and what needs have emerged for them as a result. We work with them to explore achievable ways to meet those needs.
2b	We strive to ensure that harmed patients/families can access the specialist independent advice and advocacy they require based on their individual needs
2c	Where the harmed patients/families are impacted psychologically or emotionally, we strive to ensure that they receive the appropriate support to aid their wellbeing, by listening to them and supporting the use of external expertise if needed.
2d	We listen to, and explore, how we can respond to other impacts and needs of the harmed patients/families.
2e	Where patients and their families express a desire to meet with staff, we support them to do so in ways that are safe for everyone.

Commitment 3

We support meaningful involvement of harmed patients/families in investigations or other review processes related to their treatment

Why?

Sense-making is an essential phase of recovery from a traumatic event. Giving patients/families who have been affected by harm a comprehensive, coherent and well-evidenced explanation of what has happened is crucial for them to be able process the experience. The way in which that explanation is given should contribute positively to the harmed patient/family's wellbeing, not add to their distress. Similarly, an investigation process that prioritises dignity, wellbeing, trust and just relations is one that works with those most directly involved in/affected by the event, including staff; not one that works separately from them. This approach can reduce the risk of compounded harm and increase the potential for evidence-based findings and meaningful learning.

	Essential elements of Commitment 3
3a	We provide appropriate and timely support to help patients and families prepare for and understand the processes and make informed decisions about their involvement in accordance with their preferences wherever possible.
3b	We signpost patients and families to independent sources of information, specialist advice or advocacy in relation to any investigation or learning-review process and, if necessary, consider paying for specialist independent advocacy for them.
3c	We engage with patients/families on the terms of reference of any investigation or scope of a learning response/review related to their treatment and act on their feedback, including having an open dialogue about any reasonable changes which need to be made.
3d	We ensure patient and families have the opportunity to review for themselves, and feedback on, all relevant evidence (including medical records and accounts from others) under consideration by an investigation or review.
3e	We value and respect the patient and families' account of what has happened, and we listen to and carefully consider their comments on other accounts of events.
3f	We take a compassionate and dignifying approach to sharing findings with patients and families.
3g	We include harmed patients and families in identifying what we should learn and do differently for future prevention.
3h	We strive to make the report of any review or investigation as personal and sensitive as we can, for example, by using photographs or real names and/or including an introduction written by patients and families.
3i	We support patients and families to comment on the draft investigation/review report (with the help of specialist independent advice/advocacy if appropriate) and respect and act on their feedback, incorporating changes where appropriate.
3j	We obtain, and act on, qualitative feedback from harmed patients and families about their experience of any learning process, and their broader insights.

Commitment 4

We provide harmed patients/families with opportunities to contribute to patient-safety and patient-experience improvements in a meaningful way.

Why?

For many patients and families, meaning making is a helpful part of their healing journey. Having opportunities to do something positive with the insights gained from the experience can bring comfort and purpose and make a huge difference to their ability to move forwards. Organisations that value the contributions made by harmed patients/families, and are inclusive and supportive of their participation, make an important contribution towards the patients/families healing and are better able to make meaningful, lasting improvements.

	Essential elements of Commitment 4
4a	We strive to offer all patients/families meaningful opportunities to use their experience, knowledge and skills to help inform improvements within our organisation. We acknowledge all patients/families have different views and their desires to take on such opportunities will vary.
4b	We strive to offer patients/families affected by harm events opportunities to share the facts of their case in meaningful ways including details about the impacts the events have had on them.
4c	We strive to offer harmed patients/families opportunities for wider involvement in our patient safety/experience work so that they can use their experience for positive change.

Commitment 5

We respect that harmed patients/families may choose to use external or parallel processes to seek answers and accountability as well as to improve safety for others. We will not allow this to change or needlessly delay our engagement with them.

Why?

Harmed patients/families who do not feel their needs have, or can, be met via the organisation's own processes are likely to explore other processes and, indeed, have a right to do so. Organisations must be understanding and respond by helping them access reliable information about external processes. This is essential to avoid compounded harm and to help guard against further damage to trust and confidence.

	Essential elements of Commitment 5
5a	When it appears that harm may have been caused by our acts or omissions, we will always act in the best interests of the patient by supporting NHS Resolution's (NHSR) assessment without delay and ensuring prompt settlement of deserving claims. If litigation is still required, we will arrange or pay for additional support to minimise the distress a litigation process can sometimes cause.
5b	We do not treat patients/families any differently should there be an external or parallel process such as an inquest, complaint, legal action, fitness to practise or other regulatory process. We make this clear in any communication with patients/families.
5c	We support harmed patients/families to understand the range and aims of external processes, and signpost them to sources of specialist independent advice or advocacy (see commitment 2).
5d	We do not allow protection of our own organisation's liability, interests or reputation, or those of our staff (current or former) to adversely influence how we deal with reviews, investigations or reports about harmed patients' treatment.

Commitment 6

We prioritise human wellbeing, trust and just relations in all we do.

Why?

We know organisations that prioritise human wellbeing, trust and just relations, as a result of a Restorative Culture, are more readily able to meet human needs when things have gone wrong. When harm occurs, patients/families and staff need organisations to balance their efforts to learn and improve against the needs of the patient and their family if dignity is to be restored and compounded harm avoided. It is the culture of the organisation, not simply compliance with guidance, standards and toolkits, that has the greatest potential to deliver a just and healing response.

	Essential elements of Commitment 6
6a	Our leadership and staff accept and understand that we owe a moral duty of care to the patients/families for whose harm we are collectively responsible.
6b	Our leaders model a restorative approach and support others to do the same.
6c	We prioritise fair accountability, learning and responsibility-taking when people are harmed and do not take a defensive approach.
6d	We care about our staff's wellbeing and strive for their psychological safety so that they feel as comfortable as possible about being open and appropriately accountable in relation to patient-harm events.
6e	We care for the wellbeing of, and fully support, staff working in after-harm processes.
6f	Across the organisation, we invest in the right people, knowledge and skills to enable responses to harm events based on restorative principles.
6g	We ensure our systems, policies and procedures are aligned with our values and restorative principles.
6h	Harmed patient/family insight and knowledge is valued in our organisation, and we seek out opportunities to embrace it.
6i	We have robust governance arrangements for the Harmed Patient Pathway, including having a senior member of the board with responsibility for this.

Glossary

Accountability
Being answerable for your actions. When something goes wrong, the people or organisations involved must tell the truth about what happened and explain their part in it. Occasionally, they may also need to accept a consequence related to unacceptable actions.

Compounded harm
Extra harm that a patient and their loved ones can experience after being harmed because of processes they have to go through or how people behave. This could be people who provided the care when harm happened, institutional leaders and decision makers, or people working within processes like investigations, complaints, inquests and compensation claims. Harmed patients and families may feel ignored, uncared for, disbelieved, or that people are being defensive. Sometimes this extra harm can feel even worse than the first harm.

Dignity
Our inherent value and worth as human beings. To be treated with dignity is to be seen, heard, listened to, supported and treated fairly.

Just culture
A fair way of working in healthcare that values both patients and staff. It helps stop problems before they happen and makes sure people are treated fairly and honestly if they do. Being open about mistakes means honest explanations can be given, lessons can be learned, and mistakes can be avoided in future.

Moral harm
When our own actions, or actions of others, do not live up to our normal expectations of what we or others we rely on should, and will do. Moral harm has been described as having ‘the rug pulled from beneath you’ when trust and confidence is broken.

Moral repair
The process of restoring trust and confidence. Moral repair includes acknowledging harm, taking appropriate responsibility, and agreeing reasonable obligations for both repair and prevention.

Patient harm
When something happens during a patient’s care or treatment to cause pain, injury, upset, or other bad effects for them or their family. This harm can be to the body, the mind, feelings, trust and relationships. Harm can also include upset caused by a healthcare worker being unkind or lacking compassion.

Professional duty of candour
Healthcare professionals must be open and honest with patients when something goes wrong with their treatment or care. This means patients and their families should be told what happened as soon as possible and be given a proper apology. Being honest is part of the professional rules for healthcare workers.

PSIRF
The Patient Safety Incident Response Framework is the NHS's plan for how to respond when something goes wrong in patient care. It helps the NHS learn from mistakes and improve safety. All NHS-funded care providers must follow PSIRF. It includes compassionately engaging with harmed patients and families and involving them in learning processes if they want to. This approach to involvement in learning processes is included in the Harmed Patient Pathway.

Relational harm
When a relationship with others (individuals, groups or institutions) is damaged by an event such as patient harm from a safety incident, or behaviours in response to the original harm event. Often there is a need for actions that can set relations right, and the absence of these actions can contribute to ongoing distress and affect wellbeing.

Relational repair
Actions taken to address relational damage and try to set relations right. This may include acknowledgement of the harm caused, taking appropriate responsibility, sincere apology and agreeing actions aimed at repair and prevention.

Responsibility
Having a duty to act in the right way when something happens. This could be because of your job, your position, or your morals. It means responding in a way that looks after the needs and rights of everyone affected. In big, complex organisations, this is often done together as a team.

Restorative justice
An approach to justice that focuses on what an event has done to people, trust and relationships, and what is needed to repair the harm to the extent possible, and prevent harm in the future.
Restorative justice processes support connection, curiosity, and authentic communication to enable mutual understanding of what has happened, how it has happened, and the impacts it has had on everyone affected. In restorative justice processes everyone plays a part in finding a constructive way forward, that support appropriate and fair accountability, healing and just outcomes for all affected by and connected by the events

Restorative learning
A way of learning after something goes wrong in patient care. Patients, families, healthcare workers, and organisations work together to understand what happened, and agree changes to stop it happening again. It focuses on trust, taking responsibility, and always trying to improve.

Statutory duty of candour
When something goes wrong in health or care services, patients and their families have the right to be told clearly and quickly what happened, and to receive a proper apology. Statutory duty of candour only applies to notifiable safety incidents.

Annex A: The Genesis of the Harmed Patient Pathway

Work on developing the Harmed Patient Pathway came about as a result of the Harmed Patients Alliance (HPA) sharing their insights and vision for a care pathway to help address the causes of compounded harm with Action against Medical Accidents (AvMA) who had been doing work to better understand the needs of patients and their loved ones following harm experienced in healthcare.

HPA had been founded in 2020 because of the frustration of its co-founders with responses to harm that were not developed through the lens of 'care' with the aim to do no more harm and help harmed patients and families cope, heal, and recover as best they can from 'healthcare harm' and it's impacts. Rather than being considered a 'potential risk' to be managed within transactional or adversarial processes, HPA's vision is that harmed patients and their families are seen, compassionately, as a patient group to whom a duty of care is owed by the NHS, to both understand and attend to their healing and justice needs in ways that support health and wellbeing. This focus on a duty to 'do no more harm' and support a path to healing should be morally expected from the National 'Health' Service and recognised as integral to any notion of a Restorative or Just Culture in Healthcare.

AvMA, the UK charity for that supports people who are avoidably harmed through healthcare, as well as drawing on its experience over 40 years in supporting harmed patients, had been undertaking engagement work with its supporters (patients and/or their loved ones who have experienced harm) and mapping out their 'journey' following harm and to what extent their needs are met or not met by the processes on offer after harm and the approaches taken by responsible organisations and personnel within them. This was intended to inform AvMA's priorities in seeking changes to current systems so that harmed patients' needs are better met.

Together, based on their insights and common goal of improving harmed patient experiences, AvMA and HPA launched the concept of the 'Harmed Patient Care Pathway' in February 2021.

Work began with first establishing an advisory group including interested staff from NHS bodies, the Healthcare Safety Investigation Branch (as it then was), and representatives of AvMA and HPA to help develop the commitments needed when prioritising care of the harmed patient and families' health and wellbeing after harm within a Restorative Just and Learning Culture. Further engagement with harmed patients, NHS bodies and regulators took place including an open consultation in 2024, which has led to the working group agreeing the current version of the underpinning commitments of the pathway.

Annex B: The Philosophical Foundation of the Harmed Patient Pathway

The Harmed Patient Pathway is based on the belief that harmed patients and their families have a range of needs specific to them in order for them to heal to the extent possible from the experience of harm having been caused, and that healthcare providers have a moral duty of care to do as much as reasonably possible to meet those needs. Such needs can be emotional and psychological as well as physical and practical. Lucien Leape described such needs as 'therapeutic necessities'.[1]

The Harmed Patient Pathway recognises that learning from incidents which have led to harm is vital not only for improving patient safety but also is often a key need for the harmed patient or their family. However, it is also intended to correct a critical imbalance: an emphasis on learning as the primary — and often sole — organisational response to harm. While learning for future prevention is vital, it may be only one of many healing needs for patients and families and not be assumed to be their priority. They require a holistic healing response. This has been recognised by a range of commentators.[2] [3] [4] [5]

While patient safety incident responses have tended to frame patient harm as a system failure with associated learning opportunity, the Harmed Patient Pathway focuses on the human experience, the harm to people and to trust and relationships, and what commitments and actions are needed to optimise healing.[6] [7]

In addition to compassionate and inclusive investigation practice and optimal learning; healing demands relational, proactive care that addresses the full spectrum of human needs for truth telling and accountability, substantive and moral repair and meaning-making after harm.[8] [9] These needs must be approached in relational rather than simply procedural or adversarial ways if the response to harmed patients and families is to be safe (does no more harm); effective (best practice with an evidence

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base); and person centred (responsive to the preferences and needs of the individuals involved). [10] [11] [12] [13]

A commitment to supporting healing after harm is is consistent with the NHS ambition to develop a 'just culture' but helps this become a just and restorative culture. In such a culture, 'just relations' are prioritised and careful attention is paid to ensuring the quality of relationships that support human wellbeing and flourishing.[14] Such a cultural prioritisation of wellbeing and relationships requires responses to harm based on the moral and substantive repair needed to address relationships under strain. A Restorative Just Culture requires an approach to professional accountability and collective responsibility-taking rooted in respect, care, concern and dignity, not just for those who work within the organisation, but for the patients and families served.

To support healing, justice and accountability after harm, in addition to asking *What happened? Why did it make sense at the time?* and *How can we reduce this risk in the future (learning),* we must also ask *Who is affected, What do they need,* and *Whose moral obligation it is to meet that need?*, so that no more harm is done to those involved and healing, learning, trust and just relations can be achieved. This focus on harm and repair as a justice mechanism is in contrast to a blame culture focused on finding a wrongdoer and seeing them punished. In most cases of patient harm there is not a 'wrongdoer' per se, harm has emerged, despite the benevolent intentions of professionals, because of normal human potential to make mistakes and a system that doesn't always make this easy to avoid. The Harmed Patient Pathway seeks to embed restorative practice into responses to harm. [15] [16] [17] The intent is a response that enables meaningful accountability and responsibility-taking for harms caused, without the need for unjust blame or adversarial punitive processes that can compound harm. This approach does not mean that disciplinary or regulatory action should not be taken when justified. Neither should it compromise the patients' right to access the complaints process or litigation if they feel this necessary to meet their needs.

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[10] Ramsey L, Sheard L, Waring J, Mchugh S, Simms-Ellis R, Louch G, et al. Humanizing processes after harm Part 1: Patient safety incident investigations, litigation and the experiences of those affected. Frontiers in Health Services. 2024;4:1473256.
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[13] Foundation TH. Quality Improvement Made Simple2021. Available from: https://www.health.org.uk/resources-and-toolkits/quick-guides/quality-improvement-made-simple.
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The term care pathway is deliberately chosen over communication, involvement, or resolution process. A process implies a transactional series of steps aimed eventually at administrative closure. A care pathway, by contrast, recognises the therapeutic, human-centred and relational ongoing nature of healing after harm. It focuses on walking alongside those affected, responding to their evolving needs, to restore wellbeing trust and relationships over time.

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