

Healthwatch Surrey guidance on involving people in Patient Safety Incident Response Plans

About Healthwatch Surrey

Healthwatch Surrey is an independent service, empowering the residents of Surrey to have their voices heard. We seek out people's experiences of health and care services and share these with service providers and decision makers, to support services to improve and tackle health inequalities. We believe that health and social care providers can best improve services by listening to people's experiences.

Our guidance

This guidance is designed to share the Healthwatch Surrey perspective to help organisations develop Patient Safety Incident Response Plans that enable a positive culture of listening and involvement following a safety incident. NHS England's supporting guidance on [engaging and involving patients, families and staff](#) provides a clear statement of the importance of this:

'The PSIRF supports development of a patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents.

Those affected' include staff and families in the broadest sense; that is: the person or patient (the individual) to whom the incident occurred, their family and close relations. Family and close relations may include parents, partners, siblings, children, guardians, carers, and others who have a direct and close relationship with the individual to whom the incident occurred.'

Our guidance provides some considerations for how to involve people in the design of a plan and throughout an investigation.

Designing a plan

Healthwatch Surrey would strongly suggest that providers consider developing their plan *with* people who use their services, as well as their families and carers. Our principled belief as the champion of patient and public involvement, is that it is best practice to have a diverse range of inputs into the development of policies and plans, including patient/service user/family/carer perspectives. If these diverse perspectives are included from the outset, this can help ensure that the policies and plans themselves are designed to promote patient/family/carer-centred involvement, and do not of themselves create unintended barriers to that involvement. It is our experience that incorporating a degree of co-design of policies and plans themselves is the best way to achieve greater involvement. If an organisation commits to co-designing their plan, people should be involved as soon as possible. We suggest that this process involves people who are most at risk of health inequalities and their carers. It would also be beneficial to involve other external partners such as voluntary, community or social enterprise (VCSE) organisations to support this process and also to ensure a diverse representation of experiences. We would encourage providers to consider this and whether patient safety partners provide sufficient representation.

Clear communication of a timeline for an investigation is important in informing all people involved of what to expect from a process. We would welcome a commitment to keeping all parties informed at regular intervals throughout an investigation, providing all people involved with a point of contact should they have any concerns or additional feedback. The final outcome of the investigation must be provided to all the people involved, which highlights what actions are to be taken. We would also welcome the provision of an opportunity for people involved to discuss any additional concerns at this stage.

Towards inclusive involvement

A safety plan should provide guidance and advice to ensure any barriers to involvement and inclusion are identified and appropriate support is in place for all involved.

Patients, families, carers and staff will have a range of needs that may impact their involvement in any investigation. Any plan should identify and accommodate any accessibility needs as well as sensitivity towards cultural backgrounds that might influence a person's ability to be involved. We would suggest that any training provided also includes information regarding adjustments for different communication or accessibility needs for staff, patients and families.

We would welcome a commitment throughout a patient safety plan to facilitating alternative opportunities for people to be involved. In some cases, people are not willing to feedback directly and might prefer to speak anonymously with an independent organisation such as Healthwatch or communicate through an advocate or carer. We also suggest that partnerships with other organisations be recognised as important to connect with people who might otherwise not be heard, particularly consider working with VCSE organisations or other groups with established links with communities.

It is important that the published version of this guidance is provided in clear and concise language, free of jargon or acronyms, that demonstrates what to expect from an investigation. All communications, policies and plans should be made available in alternate formats such as Easy Read and would encourage organisations to consider other formats as appropriate for the people who use their services.

Further considerations

A safety plan is vital for not only preventing harm in individual cases but in providing assurance against wider harm occurring. It would be beneficial for investigations to consult with external organisations such as Healthwatch or other relevant partners to include a wider range of patient feedback, both formal and informal, to ensure that there is adequate opportunity to assess the scale of an emerging theme or issue.

We suggest that plans also include a process for evaluating involvement and suggest follow ups to incident reviews where people have not been involved for any reason. Providers could consider reviewing these within any relevant internal patient and/or staff forums as well as within external

quality forums such as Place quality groups to highlight any barriers and explore if any changes need to be made to improve future involvement.