

Classification: Official

Publication approval reference: PAR1465



Patient Safety Incident Response Framework supporting guidance

Engaging and involving patients, families and staff following a patient safety incident

Version 1, August 2022

Contents

| | |
|---|----|
| Introduction..... | 3 |
| Importance of compassionate engagement and involvement..... | 4 |
| Developing this guidance..... | 5 |
| How to use this guidance..... | 6 |
| Scope..... | 7 |
| Engagement principles..... | 8 |
| Part A: Creating the right foundations..... | 11 |
| Leadership..... | 11 |
| Training and competencies..... | 11 |
| Support systems..... | 14 |
| Ensuring inclusivity..... | 14 |
| Information resources..... | 15 |
| Processes for seeking and acting on feedback..... | 16 |
| Processes for managing dissatisfaction..... | 16 |
| Part B: Engagement and involvement process..... | 18 |
| Before contact..... | 20 |
| Initial contact..... | 21 |
| Initial contact: patient safety incident investigation..... | 25 |
| Continued contact..... | 25 |
| Continued contact: patient safety incident investigation..... | 28 |
| Closing contact..... | 31 |
| Closing contact: patient safety incident investigation..... | 32 |
| Additional considerations..... | 35 |
| Assessing risks throughout engagement..... | 35 |
| Keeping good records..... | 35 |
| Addressing communication barriers..... | 36 |
| Using language services..... | 36 |
| When communication breaks down..... | 37 |
| Considerations when other responses are ongoing..... | 37 |
| Media involvement..... | 39 |
| Working with representatives and no responses..... | 40 |

| | |
|---|----|
| Working with representatives and indirect communication | 40 |
| No responses..... | 40 |
| Glossary | 42 |
| Useful resources and references..... | 44 |
| Appendix: Example survey questions for seeking feedback | 46 |

Introduction

Many national reports^{1 2} clearly articulate the importance of engaging with patients, families, and staff appropriately after a patient safety incident and involving them in any subsequent investigation.

While healthcare organisations have undoubtedly increased their focus on engagement with and involvement of patients, families and staff, the way they do this in patient safety incident investigations remains varied. Many of those affected still feel excluded from the process.

The [Patient Safety Incident Response Framework](#) promotes systematic, compassionate, and proportionate responses to patient safety incidents, anchored in the principles of openness, fair accountability, learning and continuous improvement – and with the aim of learning how to reduce risk and associated harm.

The PSIRF recognises that meaningful learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. 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 patient³ (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.

This document uses the term ‘engagement lead’ to refer to anyone who leads on engaging with and involving those affected by a patient safety incident. This may be a person leading a learning response or a family liaison officer (or similar).

¹ [Final report of the Ockenden review](#)

² [The Early Notification scheme progress report: collaboration and improved experience for families](#)

³ Although some prefer the term service user, ‘patient’ is used throughout this document for simplicity

Involvement has been part of investigations policy for some time, but to date those working with patients, families and staff during investigations have had no specific national framework or guidance to help them do so. This guidance addresses that gap and replaces [Being Open](#) as the national standard for engaging with those affected by a patient safety incident and their subsequent involvement in any learning responses.

This document helps staff in patient and family liaison (or equivalent) roles engage and involve patients, families and staff following a patient safety incident. It also supports organisational leaders (and their teams) to develop enabling systems and processes as required by the [Patient Safety Incident Response Framework \(PSIRF\)](#) and associated Patient safety incident response standards.

Importance of compassionate engagement and involvement

The term **engagement** describes everything an organisation does to communicate with and involve people affected by a patient safety incident in a learning response. This may include the Duty of Candour notification or discussion, and actively engaging patients, families, and healthcare staff to seek their input to the response and develop a shared understanding of what happened.

Compassionate engagement describes an approach that prioritises and respects the needs of people who have been affected by a patient safety incident.

Involvement is part of wider engagement activity but specifically describes the process that enables patients, families, and healthcare staff to contribute to a learning response.

There are compelling moral and logical arguments for engaging with those affected by a patient safety incident and involving them in a learning response.

First, those affected by a patient safety incident may have a range of needs (including clinical needs) as a result and these must be met where possible. This is part of our duty of care. Meeting people's needs not only helps alleviate the harm experienced, but also helps avoid **compounding** that harm⁴. While we cannot change the fact that an incident has happened, it is always within our gift to compassionately engage with those affected, listen to, and answer their questions and try to meet their needs.

Second, engaging with those affected by a patient safety incident substantially improves our understanding of what happened, and potentially how to prevent a similar incident in future. Patients, their family members, and carers may be the only people with insight into what occurred at every stage of a person's journey through the healthcare system. Not including those insights could mean an incomplete picture of what happened is created. Similarly, staff have important contributions to make about their experience of the incident and the working environment at the time and should be supported to share their account.

Developing this guidance

This guidance was developed by the National Patient Safety Team, the Healthcare Safety Investigation Branch, and members of the 'Learn Together' research team. Building on the extensive co-design work of the Patient and Family Involvement in Serious Incident Investigation ('Learn Together') research project funded by the National Institute for Health Research, we brought together a wide group of stakeholders to agree and ratify the final guidance. Stakeholders included PSIRF patient partners, patients and staff with lived experience of Serious Incident investigations, researchers, patient advocates, NHS family liaison officers, and those undertaking or managing patient safety investigations and responses (ie patient safety managers and learning response leads).

This guidance is based on the available evidence at the time of publication and it will be evaluated over the coming year using an independent national survey undertaken by the Learn Together research team. The survey findings will be combined with the Learn Together programme's broader evaluation, to inform the next iteration of this guidance (expected to be published in 2023/24).

⁴ Compounded harm is the harm that some people – particularly patients and families – can experience when investigations following safety incidents are handled in ways they feel are closed and defensive (even if that is not the intention of those leading the process).

How to use this guidance

This document has two parts:

- **Part A: Creating the right foundations** describes the systems and processes that establish strong foundations on which an effective involvement process can be built. This guidance is for those responsible for PSIRF implementation and those in system oversight roles.
- **Part B: Engagement and involvement process** describes a process for engaging those affected by patient safety incidents and supportively involving them throughout a learning response, and while it focuses on patient safety incident investigation (PSII) it can be applied to other learning response methods. This practical guidance is aimed at those working directly with people affected by patient safety incidents (eg learning response leads and family liaison officers).

Scope

This guidance focuses on **how to achieve compassionate engagement and involvement** by:

- supporting healthcare organisations to review and amend the systems they have in place to ensure an effective process of engagement and involvement with those affected by patient safety incidents
- providing practical advice to support compassionate engagement with those affected by patient safety incidents
- providing practical advice to enable meaningful involvement as part of a patient safety incident investigation (PSII), although the principles and approaches described can be applied to any type of patient safety incident and/or response method.

The role of **support**⁵ (physical or psychological) for those affected by patient safety incidents is integral to this focus. Although this document does not cover how to provide support, it does prompt staff to consider if the correct support mechanisms are available and, where necessary, signpost to other professionals, agencies or groups so that patients, families, carers and staff are ‘supported’ through an investigation process in accordance with their personal needs.

This document does not cover restorative healing, which is a specific method that must be carefully facilitated by trained individuals. Instead, the guidance is designed to prevent compounded harm during the investigation. The Learn Together study found that those affected by patient safety incidents overwhelmingly felt that a compassionate approach to investigation would help them feel supported and reduce any additional harm, such as erosion of trust in the organisation and feelings that duty of care had been removed.

⁵ Support is assistance or comfort, which aims to assist people in coping with a variety of issues, according to their individual needs. In the context of patient safety incidents, support may be for physical, psychological or information and advice or advocacy needs. Support can be provided directly by the healthcare provider; by the person’s own family, friends, or networks; or by independent organisations or individuals specialising in different forms of support.

Engagement principles

Alongside the advice in parts A and B, nine principles should inform the design of an organisation's systems and processes for engaging and involving those affected by patient safety incidents. Due to the range of incidents that can occur, and the different needs of individuals affected, the principles should be flexibly applied when engaging with or involving those affected by patient safety incidents in an investigation⁶.

1. Apologies are meaningful

Apologies need to demonstrate understanding of the potential impact of the incident on those involved, and a commitment to address their questions and concerns. Ideally, an apology communicates a sense of accountability for the harm experienced, but not responsibility for it ahead of investigation. Getting an apology right is important – it sets the tone for everything that follows. Apologising is also a crucial part of the [Duty of Candour](#).

2. Approach is individualised

Engagement and involvement should be flexible and adapt to individual and changing needs. These needs could be practical, physical, or emotional. Engagement leads should recognise that every response might need to be different, based on an understanding of the different needs and circumstances of those affected by an incident.

3. Timing is sensitive

Some people can feel they are being engaged and involved too slowly or too quickly, or at insensitive times. Engagement leads need to talk to those affected about the timing and structure of engagement and involvement, and any key dates to avoid (eg birthdays, funeral dates, anniversaries), particularly where someone has lost a loved one.

4. Those affected are treated with respect and compassion

Everyone involved in a learning response should be treated respectfully. There should be a duty of care to everyone involved in the patient safety incident and subsequent

⁶ These principles are aligned with the obligations of Duty of Candour that organisations must uphold

response, and opportunities provided for open communication and support through the process. Overlooking the relational elements of a learning response can lead to a breakdown of trust between those involved (including patients, families, and healthcare staff) and the organisation.

5. Guidance and clarity are provided

Patients, families, and healthcare staff can find the processes that follow a patient safety incident confusing. Those outside the health service, and even some within it, may not know what a patient safety incident is, why the incident they were involved in is being investigated or what the learning response entails. Patients, families, and healthcare staff can feel powerless and ill-equipped for the processes following a patient safety incident. Therefore, all communications and materials need to clearly describe the process and its purpose, and not assume any prior understanding.

6. Those affected are ‘heard’

Everyone affected by a patient safety incident should have the opportunity to be listened to and share their experience. They will all have their individual perspective on what happened and each one is valid in building a comprehensive picture to support learning. Importantly, the opportunity to be listened to is also part of restoring trust and repairing relationships between organisations and staff, patients, and families.

7. Approach is collaborative and open

An investigation process that is collaborative and open with information, and provides answers, can reduce the chance litigation will be used as a route for being heard. The decision to litigate is a difficult one. Organisations must not assume that litigation is always about establishing blame – some feel it is the only way to get answers to their questions.

8. Subjectivity is accepted

Everyone will experience the same incident in different ways. No one truth should be prioritised over others. Engagement leads should ensure that patients, families, and healthcare staff are all viewed as credible sources of information in response to a patient safety incident.

9. Strive for equity

Organisations may differ from patients, families, and healthcare staff in what they consider is the appropriate response to a patient safety incident. The opportunity for learning should be weighed against the needs of those affected by the incident. Engagement leads need to understand and seek information on the impact of how they choose response types on those affected by incidents and be aware of the risk of introducing inequity into the process of safety responses.

Part A: Creating the right foundations

Systems and processes need to be carefully designed if engagement is to meet the needs of those affected and involvement is to produce meaningful learning for improvement.

Figure 1 highlights the systems and processes that are the foundations for effective and compassionate engagement. Further detail is given below.

Leadership

Compassionate engagement starts with recognising the importance of this work – at all levels of the system from NHS England to integrated care systems, trusts, executives, and individuals.

Managers and/or leaders should demonstrate their commitment to compassionate engagement and involvement in their words and actions.

Engagement and involvement must be communicated as a genuine priority and not a formality. For example, investment should be made in developing expertise in patient, family and staff support, engagement and involvement (eg through providing dedicated time and training for those undertaking and/or developing specific liaison roles across the organisation or system as required).

Training and competencies

PSIRF sets specific expectations regarding the training and competencies required for engaging and involving those affected by patient safety incidents.

Engagement leads must attend a minimum of six hours of training in ‘Involving those affected by patient safety incidents in the learning process’ (see [Oversight roles and responsibilities specification](#) for further information on training requirements). The training must cover:

Figure 1. Foundations for effective and compassionate engagement



Leadership

Managers and leaders should demonstrate their commitment to compassionate engagement and involvement in their words and actions.



Training and competencies

PSIRF sets specific expectations regarding training required for engaging and involving those affected by patient safety incidents.



Support systems

Families and staff may need to be signposted to support at any point during engagement or involvement in a learning response.



Ensuring inclusivity

Engagement and involvement must take into account individual needs. Organisations should consider this in the design and delivery of their service.



Information resources

Those affected by a patient safety incident must have clear information about the purpose of a learning response, and what to expect from the process.



Processes for seeking and acting on feedback

Organisations must assess the progression and outcome of engaging with those affected by a patient safety incident and their involvement in a learning response.



Processes for managing dissatisfaction

When the expectations of those affected are not met, families and staff must be given meaningful, truthful and clear explanations as to why this was not possible.

- Duty of Candour
- just culture
- being open and apologising
- effective communication
- effective involvement
- sharing findings
- signposting and support.

The [patient safety incident response standards](#) specify the competencies required of engagement leads, including the ability to:

- communicate on highly complex matters and in difficult situations
- communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way
- listen and hear the distress of others in a measured and supportive way

These competencies must be applied in all forms of communication with those affected by patient safety incidents (letters, emails, face to face, telephone calls, etc.) and communication styles must be adapted to meet the needs of different people, including consideration of **an individual's ability, culture, beliefs and preferences**, as well as appropriate adjustments such as translation services.

Communication skills are vital and their inclusion in job descriptions and coverage in recruitment should be considered. **Engagement leads must have the competencies to actively listen, show openness, demonstrate empathy, and create a rapport with those affected.** Good communication skills and being open and honest will enable engagement leads to effectively manage expectations.

Communication should be a two-way dialogue to allow the imparting and receipt of helpful and accurate information. The use of plain language and avoiding jargon or acronyms will aid understanding. Where appropriate, checking understanding and summarising can ensure the intended message has been received and is understood.

Good communication must continue throughout the PSII, providing updates where appropriate and as agreed with those affected.

The [NHS training and development framework](#) will help organisations identify training providers for the required one- and two-day training courses.

In addition to training, engagement leads are required to stay up to date with best practice; for example, by attending conferences, webinars, etc.

Support systems

Families and staff may need to be signposted to support at any point during engagement or involvement in a learning response. Organisations should ensure there is equity in the support offered to families and staff, and that systems exist for internal and external support so that those affected can access support in the way they prefer wherever possible.

Sources of support for families may include bereavement and mental health services as well as via independent advocacy services, and for staff, mental health first aid, [Second Victim Support](#)⁷ and local occupational health services (see also HSIB report: [Support for staff following patient safety incidents](#)).

Organisations should review, where possible, the support offering of the organisations they signpost to ensure they have the resources to respond. Signposting should be adjusted as appropriate, or organisations may wish to consider commissioning independent advice/advocacy.

Engaging with families and staff affected by a patient safety incident is demanding and the challenges of the role should be recognised. Engagement leads should have access to support and the sources made available and known to them; these may include direct line management support, peer support and mental health first aid.

Ensuring inclusivity

Engagement with those affected and their involvement in PSIs must take account of individual needs. Organisations should consider this in both the design and delivery of their service. For example:

- wherever possible patient safety partners⁸ should be involved in co-producing the design, delivery and review of the processes outlined in this guidance

⁷ Healthcare employees whose personal or professional lives have been significantly affected by a patient safety incident can be referred to as second victims.

⁸ [NHS England » Framework for involving patients in patient safety](#)

- the diversity of patient safety partners involved in any planning should be considered to ensure they reflect the population the organisation serves
- language services should be easily accessible by engagement leads.

The individual affected is the best person to advise on what their needs are, and they should be acted on where appropriate.

Information resources

As described in the engagement principles, those affected by a patient safety incident must have clear information about the purpose of a learning response, and what to expect from the process. Organisations will need to provide this information to those affected.

Any information should ideally contain:

1. what a patient safety incident is
2. what a learning response is, and what the different types of response are
3. definitions of key words and phrases (see the glossary at the end of this guidance for ideas)
4. ways to involve those affected, and how they can prepare for this involvement
5. support resources (local and national).

Resources should be made available in both **digital** and **physical** formats, recognising that not everyone will have access to an electronic device. Special attention should be paid to how the information is presented, its tone, the reading age it is pitched at, its understandability by those whose first language is not English, etc. Patient safety partners and staff with lived experience can play an important role in reviewing any information resources to be shared with those affected by patient safety incidents.

The Learn Together research team has co-produced materials to support involvement in learning responses:

- **Investigator guidance:** supports investigators to involve patients, families, and staff in learning responses.
- **Patient and family information booklet:** informs the patient and their family about how to get involved in learning response.

- **Staff information booklet:** informs staff about how to get involved in learning response.
- **Investigation record:** supports and prompts investigators to undertake specific involvement activity in individual investigations.

NHS organisations can [download](#) and use drafts of these resources in their responses. They are being tested as part of the Learn Together research programme and feedback will inform their further revision ahead of publication of final versions alongside the PSIRF involvement guidance in 2024.

Processes for seeking and acting on feedback

Organisations should be curious about the effectiveness of their processes for engagement and involvement as well as the efficacy of the support services they signpost to. They must systematically assess the progression and outcome of engaging with those affected by a patient safety incident and, where appropriate, their involvement in a learning response.

Organisations should seek feedback from a range of people and in a variety of ways, such as throughout the response process or more informally having an open conversation with those affected about their experience of the involvement and any support they have received. This could be supplemented with surveys – see Appendix for example questions. Surveys should be concise to minimise the demand they put on those asked to complete them, and available in multiple formats.

Processes should be in place to collate and make changes in response to feedback. Specific feedback may require an individual response.

Where possible, feedback from patient safety incident response should be collated with that from other teams, eg Patient Advice and Liaison Service (PALS), to drive further improvement.

Processes for managing dissatisfaction

When the expectations of those affected are not met, families and staff must be given meaningful, truthful, and clear explanations as to why this was not possible.

Processes must be in place to support the resolution of complaints or concerns raised, and wherever possible mechanisms to support open communication should be used (see section 'When communication breaks down').

Part B: Engagement and involvement process

When a family or staff member informs an organisation that something has gone wrong, they must be taken seriously from the outset, and treated with compassion and understanding.

Aligned with the [Duty of Candour](#), this part describes a process for achieving compassionate engagement with those affected by patient safety incidents.

The process described can be applied to any type of patient safety incident. Where applicable, further information is given on how to involve and support those affected throughout a patient safety incident investigation (or other learning response method).

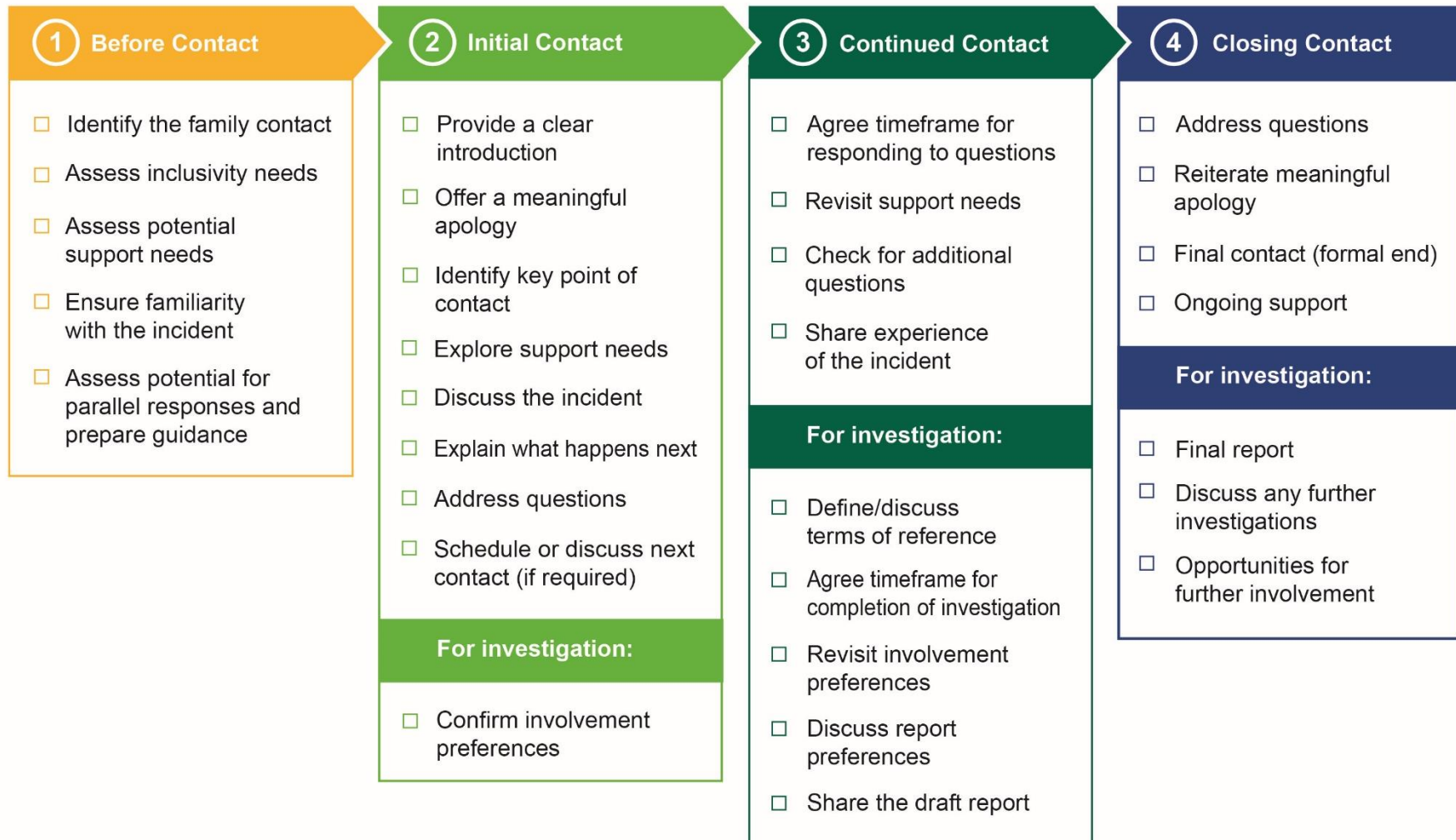
Figure 2. below provides an overview of the four steps of engagement.

Not all steps may be required, some steps may need to be repeated and the process may not be as linear as implied. Your approach must be adapted to meet the circumstances of each patient safety incident and the individuals affected. For example, careful consideration must be given to the sequence (including timing in relation to the incident, such as avoiding the anniversary of a death) and complexity of what is being asked of those being engaged and involved, remembering that this can be emotionally demanding for them.

Engagement and level of involvement must be in keeping with the wishes of those affected as far as possible.

Organisations are encouraged to use the overarching framework described in the following sections as a guide in building their own systems and processes in collaboration with patient partners and/or those with lived experience.

Figure 2. Four steps of engagement



Before contact

Compassionate engagement and involvement of those affected by patient safety incidents is demanding but incredibly important. Engagement and involvement need to be tailored to the particular circumstances of a patient safety incident response and to each individual affected, so preparation for initial conversations with those involved is crucial.

Identify the family contact

You need to identify the main family point of contact prior to commencement of any engagement. Note this contact may change.

Assess inclusivity needs

Although the initial contact needs to be prompt, care and consideration should be given in its planning. The staff member making the initial contact with someone affected by a patient safety incident should ask themselves a series of questions, including:

- What is known about the people affected by and the circumstances of the incident?
- Do those affected have any specific communication needs?
- What engagement has occurred so far and have any specific needs been identified?

The nine protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation need to be considered and appropriate adjustments made if required (eg involvement of an interpreter; see also Using language services below). Wider health inequality variables (eg mental health conditions) that can affect care that people receive should also be considered.

Assess potential support needs

Some patient safety incidents may leave people suddenly bereaved and/or experiencing complex trauma. Those affected may not be ready to participate in engagement activities for various emotional, psychological and/or physical reasons. In these circumstances the initial contact with them must be carefully planned so that support needs can be identified and met at the earliest opportunity.

Staff may have been involved in previous patient safety incidents or supported/witnessed other colleagues engaging with the learning response process, and this may heighten

their anxiety about what to expect. The initial contact with such staff may need to be longer.

Ensure familiarity with the incident

You should be familiar with the facts of the incident to date and know who you are talking about (the patient's name) and who you are talking to (eg patient, next of kin, staff member).

Assess potential for parallel responses and prepare guidance

The patient safety incident may prompt responses that run in parallel to or affect the timeframe of your response, eg a coroner's inquest. If you know of any other processes that will run, you should prepare to inform those affected of this.

Initial contact

Initial conversations with anyone affected by a patient safety incident set the tone for future interactions; establishing trust and respect at the outset is key.

You need to give careful consideration to the timing of your initial contact – for example, this may not be appropriate when patients are still undergoing medical treatment, and for a staff member, the end of their shift is probably not the best time.

You also need to recognise at the initial contact if the person affected by a patient safety incident is not ready to engage – because they are distressed, grieving or for any other reasons.

Where possible you should make the initial contact in person – staff should not be informed by email or third hand about their involvement in a patient safety incident.

Provide a clear introduction

You should introduce yourself clearly, eg by providing:

- your full name (and repeat it if needed)⁹
- your role title and work location (eg specific hospital or trust name)

⁹ Throughout conversations with those affected ask if they have any questions or need any further information about anything.

- what your role entails and how engagement following a patient safety incident usually proceeds (you could show them the overview in Figure 2, supplementing/adapting it as appropriate locally).

Offer a meaningful apology

You should give patients, their families, and carers a meaningful apology – one that sincerely expresses sorrow or regret for the harm that resulted from the patient safety incident.

Face-to-face verbal apologies are preferable, and as soon as possible after an incident has occurred. A written apology clearly stating the healthcare organisation is sorry for the suffering and distress resulting from the incident must also be given.

Do not delay giving a meaningful apology for any reason as doing so is likely to increase the family's anxiety, anger, or frustration.

Apologising is the right thing to do; it is not an admission of liability. Patients have a right to expect openness in their healthcare.

The professional Duty of Candour provides information that supports you in making an apology. You must uphold obligations relevant to both the professional and statutory Duty of Candour.

Refer also to the four Rs of an apology (regret, responsibility, reason and remedy) in the Scottish Public Services Ombudsman's '[How to make a good apology](#)' and NHS Resolution guidance on '[Saying sorry](#)'.

Identify key point of contact

Ensure those affected know who their point of contact is within the organisation. The initial point of contact from the organisation may not be the same as the person who subsequently maintains contact throughout the engagement process.

Explore support needs

Everyone will respond differently to incidents, and some people will be more aware of their support needs than others. Not everyone will need support and needs may change over time.

You need to determine if someone needs support and if they do to respond appropriately. Needs may stem from being involved in the patient safety response and/or be pre-existing. Consider the following:

- **Does this person need support?** People may not be aware that they need support, even if the incident was particularly traumatic. You may wish to tell someone about the support options available, and then give them the time and space to decide if they need such support.
- **If so, what type of support?** Support needs can manifest in different ways. They can be emotional, practical, or psychological. You should try and prompt people to think about the different types of support they may need.
- **What support resources can you share?** Based on conversations with the individuals affected, you should offer resources or discuss what other organisations can offer but leave the individuals to decide which would be most appropriate for them.

You should inform those affected of sources of independent advice at the earliest opportunity.

Discuss the incident

Explain the patient safety incident clearly and in language appropriate to the person. Your description should be based solely on what is known at the time and you must not make any causal or outcome predictions.

Explain what happens next

Describe any immediate actions that have already been taken in response to the patient safety incident.

Describe how the organisation intends to respond in accordance with the patient safety incident response plan. That is:

- Is a learning response planned?
- Is improvement work underway?
- Will a review be conducted to understand whether further learning is required?

Explain the non-punitive nature of the response; its aim is organisational learning and improvement.

If a patient safety incident investigation is planned, you should set out how this will happen. You should:

- Give people any information your organisation produces about the process. Ask how they would like to receive information about the investigation process (eg an organisational leaflet or online resource).
- Explain the process including any likely delays. You could talk generally about your trust's patient safety incident response policy, or more specifically about how the investigation will be completed. Timeframes for completion should be discussed and, if possible, mutually agreed.
- Explain anything that has already been done. If you have already started an investigation, explain what you have done and why it was necessary to begin the investigation before involving those affected in the process.
- Ask people if they have any questions about the investigation process (see below).

Address questions

You should make time to answer any questions or concerns and address identified needs of those affected, ensuring everyone has equal opportunity to engage with the process.

If you cannot answer certain questions, be honest about this and say you will come back to them with an answer once you've gathered more information, or direct people to a source of information that could give them an answer. This may be necessary where the question being asked lies outside the scope of the learning response

Schedule or discuss next contact (if required)

At the end of the initial contact you need to agree when the next contact will be, how contact will be made and who will make it. Any promised contact must be delivered.

Effective ongoing communication will involve agreeing the frequency of future contact and the preferred method of contact. Patients, family members and healthcare staff may not welcome and even be daunted by unstructured contact (that is, without prior discussion of how and when).

People will have different communication requirements. A family or staff member in distress may need more regular contact and more detailed guidance to aid understanding and retention of information.

You should ask individuals if they would like regular contact during the engagement and/or the investigation, such as weekly or every fortnight, with frequency based on the needs of those affected and the complexity of the incident and investigation. If they do, discuss what the best form of communication is.

For those people who do not have easy access to email or video software, find out how they would like to be contacted, for example, can they be contacted by text or other instant messaging, are there any disliked methods of contact.

Ask individuals if there are any dates on which they should not be contacted. There may be significant dates on which they will not want to talk about the incident (or investigation). Also, tell them about any annual leave you have planned or any work commitments that might disrupt regular communication.

Initial contact: patient safety incident investigation

Confirm involvement preferences

An individual should be helped to make an informed decision about whether to be involved in an investigation by being given appropriate information about how the investigation will run, and how they could be involved and supported throughout the process.

You should be mindful that the family member with whom you make initial contact may not be the only family member who has useful information about the incident. You may need to engage with several family members, but where possible try and arrange for contact to be through one individual, to minimise the number of contacts. Of course, some families will want to nominate one member as the person the learning response team speaks to on behalf of the whole family; this should be discussed and documented in each case.

In early discussions, personalise your approach by finding out how family members like to be referred to; this can include preferred names and their correct pronunciation.

Continued contact

When it has not been possible to address concerns and questions raised by those affected in the initial contact or when an investigation is underway, maintaining contact is particularly important.

Although you may not always have something to update people about, you must reliably maintain contact where doing so has been agreed. If communication cannot be maintained as agreed for any reason, you should let people know as soon as possible and arrange another mutually convenient time to contact them. It is also important to be transparent about how much progress has been made since the last communication. By maintaining contact and being open, you will continue to build trust with the family and healthcare staff affected.

The timings of updates will be based on the specific circumstances of each incident and what has been agreed with the family and staff involved. The degree of physical and emotional distress they are under must always be considered, so that the timing and content of communications and activities can be managed accordingly.

Agree timeframe for responding to questions

If further information gathering is required to address questions and concerns raised, you should agree with those affected when you will respond. The time needed will depend on the nature of the incident and the questions asked.

Revisit support needs

Support needs can change over time. You should raise and discuss potential support needs throughout continued contact. Refer to the considerations in the 'Explore support needs' section above.

Adapt signposting advice as necessary.

Check for additional questions

Families and staff may lack the confidence to ask questions, particularly during the initial contact phase. You should check if they have any additional questions through the continued contact.

If questions lie outside the scope of understanding what happened and learning and improvement (eg are to do with culpability), you should support families to find people or organisations that could provide answers.

Share experience of the incident

Everyone will have their own lived experience of the care leading up to a patient safety incident and what caused the incident.

It is always important, with agreement, to understand the experience of those affected. For investigations, it is important to consider all subjective experiences.

In some circumstances understanding these experiences of the incident may be important for addressing questions or concerns raised and/or contributing to another type of learning response.

Establish what media or method the person sharing their experience finds most comfortable. Where available resources allow and the method complies with trust policy, it should be facilitated. For example, could you have this conversation on a video call or face-to face to make it easier to respond to people as they share their experience? Could you visit them at home? Could you offer people the opportunity to have someone with them while you have this conversation? They might welcome the opportunity for support.

Consider the environment in which families and staff share their experience. The conversation should take place in a quiet, relaxed setting and for staff, if possible, away from their usual place of work and not where the patient safety incident occurred. Further information on sharing experience of a patient safety incident for both staff and families can be found in the ['Interview guide'](#).

Sharing experiences can be difficult, emotional, and daunting. If people feel comfortable, they are more likely to share everything they remember about the incident and the events that surrounded it. You need to help them feel more comfortable by being transparent about how information will be recorded and used.

You should give people the time and space to share their experience with you in full. If you only have a set amount of time, be honest about this and offer to arrange a second conversation.

Thank people for sharing their experience and recognise both how difficult this may have been to do and how invaluable a contribution they have made.

Shortly after (eg 24 to 48 hours), check with the patient, family member or staff member who has provided an account of their experiences if they need any extra support. You could offer the support resources identified in response to the initial contact if these have not already been taken up.

Continued contact: patient safety incident investigation

People will want different levels of involvement in a PSII. Although their preferences might change as the investigation progresses, discussions at the initial contact will set clear expectations about how and when those affected would like to be involved. As the investigation progresses, you will need to enact the ways of working that enable involvement in the investigation process by those who want to be, and remain flexible in your continued contact in case people change their mind about being involved.

Continued contact means being open and clear about how the investigation is progressing. You need to recognise that it can be difficult for people to engage meaningfully with a system or process that they are unfamiliar with. Your continued contact with people provides them with both the opportunity and support to access those parts of the investigation process they want to be involved in, as well as updating them on the investigation's progress.

For people who want to be involved in the investigation, your continued contact with them will be very similar to your initial conversations: you will provide information, discuss experiences, answer their questions, and pay attention to support needs.

For people who do not want to be as involved, or involved at all, in your continued contact you may only need to give simple updates or basic information.

Define/discuss terms of reference

You or your team will draft the terms of reference (ToRs) for the investigation process, but you should share (checking first how it should be received) and discuss this with those involved and adjust where appropriate.

You need to explain the importance of the ToR to those affected – that is, they guide what the investigation will look at, and the questions that need to be answered during the investigation.

When sharing the draft ToR, you should:

- **Explain how the draft ToR were developed.**
- **Ask people if they have any questions not covered by the ToR.** If they do, be open about whether you think you will be able to answer them within the terms of the investigation or not.

- **Adjust ToRs where appropriate.**

If the scope of the investigation will not provide answers to their questions, support people to access different sources of information and types of investigation.

Agree timeframe for completion of investigation

Timeframes for completion of an investigation are flexible and will depend on the nature of the incident and family and staff involvement.

Provided the family and staff affected are willing and able to be involved in the decision about the timeframe, this should be set in consultation with them as part of agreeing the ToR for the PSII. A response must start as soon as possible after an incident is identified, and usually completed within one to three months.

In exceptional circumstances a longer timeframe may be needed. Where a timeframe needs to be extended, this should also be explained to those affected.

The time needed to conduct a thorough investigation must be balanced against the impact of long timescales on those affected by the patient safety incident, and the risk that action may not be taken to improve safety. Where external bodies cannot provide information within four months, a local PSII should be finalised using the information available; it may be revisited later, should new information indicate the need for further investigative activity.

Revisit involvement preferences

People may change their wishes on level of involvement as the investigation progresses. You should check that people are still happy with the preferences they expressed in the initial contact.

For people who initially did not want to be involved in the investigation, use your discretion when deciding how to revisit their preferences. If you think they may have been unsure initially, you could send a brief email or a short letter to check that this is still their view.

For people who are involved in the investigation, you can revisit this during one of your regular communications.

Depending on the progress of the investigation, you should discuss individual preferences for involvement in:

- terms of reference

- information gathering
- draft report
- final report.

Make it clear what the deadline is likely to be for contributions to each of these key parts of the investigation. This sets clear expectations and equal opportunity for everyone involved.

Discuss report preferences

PSII reports can include the name of the patient. Personalisation preferences should be discussed with the family and adopted in the draft before it is shared. It is important to remember that family members may have different preferences; these should be resolved on a case by case basis.

Share the draft report

The PSII report must be shared in draft form before it is finalised, and those affected given a realistic opportunity to influence the content before it is finalised.

You will have a good idea of what the report will contain and of the safety actions you are going to suggest. Involving those affected at this stage may feel daunting but they should have the chance to check for inaccuracies and to ask questions about the draft.

Ask if and how families and staff would like to receive the draft report and in what format. Be clear if you are unable to send the report in certain ways before it is finalised.

Be clear about what people can comment on: the boundaries, as well as what you might and might not be able to change, are best conveyed in a verbal discussion. This will set clear expectations. You could highlight those areas they should look particularly close at or include some prompts to focus their comments.

Could you have a conversation with those affected before sending them the draft report, and then arrange a time to discuss it? People will need time to read the draft report, and possibly support to access or discuss it.

Explain how you will use their comments. If you cannot change something, be honest and explain why not. People might not be aware of the organisational processes involved at this stage.

Be clear about how you will develop the final report from this draft, and any changes that will be made.

It is possible that a draft report will end up in the public domain. See further information on media involvement below.

Closing contact

The end of engagement is a point of closure for everyone involved. This can be an emotional process for people, regardless of their level of engagement and involvement during the investigation process.

By this stage you should be more aware of individuals' needs and preferences, which should enable you to close contact with them respectfully, sensitively, and empathetically. **This is important to minimise the likelihood of compounding any harm caused by the incident.**

At this point you may move on to another investigation or return to full-time clinical or operational work.

For patients, families and healthcare staff, the end of any engagement or investigation may be the start of a new normal. Some may have no choice but to learn to live with the impact of the incident on them, whether that is physically, emotionally, or psychologically. Patients and families may have to navigate additional healthcare services, or process life-changing injuries or bereavement. Healthcare staff may have to process feelings of guilt or moral injury and may question their professional ability. They may be nervous about what people think of them, or about another incident happening while they are on shift.

The engagement or investigation may have provided structure for people during a difficult time. It is important that closing contact is as positive an experience as it can be, and the potential impact of the end of the contact on everyone involved is recognised. A complaint or claim may still be ongoing.

Closing contact should be well timed and considerate and, as with all contact, known significant dates for the family and staff affected should be avoided; not doing so could mean the message is not received as intended.

Address questions

At this stage you should have the information to answer all questions or concerns raised by those affected and that are within scope, and you should share this information with them in an accessible manner – eg a letter or through a discussion. For questions that are not within scope, you should support families to find people or organisations who could provide answers or explain why that may not be possible.

Reiterate meaningful apology

Reiterate the meaningful apology you gave at the beginning of the engagement process – a sincere expression of sorrow or regret for the effect the patient safety incident had on them, and that the trust is committed to learning and improving (even if a learning response method was not used in response to this incident).

Now armed with a greater understanding of the impact of the patient safety incident, you may want to expand your original apology. If a PSII has been undertaken, you may want to outline how the trust might respond to its findings, if you know.

Final contact (formal end)

Formally close the engagement/involvement process so that all parties are aware it has been closed. People will have had different levels of engagement and how you formally close may be dependent on this.

For people with whom you have had regular contact, you can close communication at the last regular contact. You should thank them for their contributions.

Where you have had minimal contact with those affected, make them aware that the investigation has officially finished, perhaps by sending an email or letter.

Ongoing support

At the conclusion of engagement or an investigation, review the support you have signposted individuals to and consider they may need any extra support. You should be flexible in meeting people's different needs.

Closing contact: patient safety incident investigation

Final report

Receipt of the final report will mark the end of the investigation process for everyone involved.

Ask those affected if and they want to see the final report, and if they do, what the easiest format is for them to receive it in. Make it clear when they can expect to receive a copy of the final report so that it does not arrive as a surprise.

Ask people if they would like to discuss the final report. You should be prepared to discuss the report's content and answer any questions from people affected. Consider offering to discuss the report on a video call or face-to-face so that you can give immediate answers to their questions/comments, and whether they would like someone with them.

Explain how the trust will use the report. Tell people about how the trust will respond to the investigation report.

Discuss any further investigations

Although the final report will mark the end of the trust-level investigation process, other investigation processes may be ongoing or follow your investigation. Although you may not be involved in these, you should inform people affected about any processes you know about that will occur from this point, such as an inquest.¹⁰

Using your previous experience and any information you have, tell people what you know about these other investigation processes, and if you can direct them to others who will be able to give them more detail.

When the final report has been published or shared with the family, acknowledge with the family the end of your 'relationship'.

Opportunities for further involvement

Patients, family, and staff members can give valuable insight into how a trust could improve processes to reduce the likelihood of incidents happening again. If you think someone with whom you have engaged could support the trust with specific ideas for change or improvement, and may be interested in doing so, you could offer them an opportunity for further involvement.

- **Who should you talk to at the trust?** The decision to involve someone further will not be yours alone. Your trust may already have a process for involving patients in patient safety in line with the [national framework](#). You should develop a

¹⁰ See NHS Resolution learning module for staff on attending a Coroner's Court [Inquests Archives - NHS Resolution](#)

clear plan for how someone's further involvement would be supported and who would be their main point of contact.

- **Would people still have access to support?** People who agree to support the trust in this way are likely to feel positive about the opportunity, but you should still make sure there is a plan for their continued access to support.
- **How would their relationship with the trust formally close?** You should make sure that any trust colleagues they work with have a clear plan for their involvement, including how and when it will end. A lack of formal closure could leave people feeling used or compound the harm they experienced because of the incident.

Additional considerations

Assessing risks throughout engagement

Engagement leads must ensure the personal safety of the patients, families, and staff with whom they engage.

Risk assessment needs to be a dynamic process throughout the engagement and investigation process. Risk should be considered in relation to:

- people (eg adverse behaviour of the people present)
- activity (eg risks associated with an action)
- location/environment (eg allergies, safeguarding concerns).

Details of any known or perceived risk should be recorded before contacting those affected and then be regularly reviewed. Any control measures that can be put in place (eg working in pairs if visiting someone at their home or another location external to the healthcare setting) and any action taken should be recorded.

Keeping good records

Every communication should be documented, even when attempts to make contact are unsuccessful, and what was discussed recorded. This ensures an accurate audit trail, demonstrates the efforts made and allows a thorough handover if ever required. Engagement leads can also refer to this log whenever they need to confirm the conversations that have taken place, which can be helpful to people who may be finding it hard to retain information due to their individual circumstances.

Records should contain:

- date and time of all contacts, including any meetings
- method of contact (eg telephone, email)
- who was present during the contact
- purpose of contact and any information exchanged
- details of who initiated the contact
- details of non-family members or support present at any meeting

- all unsuccessful attempts to contact those affected or their representatives
- all contacts with those affected that were refused or declined, and any reasons given.

Addressing communication barriers

Engagement leads should identify any barriers to effective communication as soon as possible and make any reasonable adjustments required. They also need to recognise that they may need to make subtle changes to their communication or approach to respect an individual's culture and lifestyle.

Using language services

Engagement leads should know their organisation's process for booking language services.

Use of 'unofficial translators' - whether family members or friends, or technology such as Google translate, should be avoided as they may distort information by editing what is communicated.

Engagement leads should give as much notice as possible when requesting an interpreter, and ensure the exact dialect required is understood.

The engagement lead should speak to the proposed interpreter before a family contact – to provide some background on the patient safety incident as well as to assess the interpreter's suitability. This ensures the interpreter is aware of the nature of what they will be interpreting and will be emotionally preparedness for the conversations that may follow.

It should never be assumed that a person's ability to speak a language means they can read that language – the preferred language for written documentation should be confirmed.

Where lengthy text needs to be translated, or the language is not a common one, extra time may be needed for this. Proof reading should always be requested as the engagement lead is unlikely to be able to read and ensure the accuracy of translated material.

When communication breaks down

Sometimes, despite the best efforts of engagement leads, relationships break down. Families and staff affected may not accept or agree with the information they are given or may not wish to participate in any further engagement or investigation process.

When this happens what the engagement lead should do will depend on the stage the process has reached when those affected change their minds about being engaged or involved in the investigation. The following strategies may help:

- Offer the family or staff member another contact person with whom they may feel more comfortable. This could be another member of the team or the person with overall responsibility for clinical risk management.
- Use a mutually acceptable mediator to help identify the issues between the healthcare organisation and the patient, and a mutually agreeable solution.
- Ensure family and staff members are fully aware of the formal complaint procedures.
- Write a comprehensive list of the points of disagreement and follow-up the issues.

Considerations when other responses are ongoing

Any of the below listed responses may take place concurrently with, or following, the trust-level response to a patient safety incident.

Complaints

There is a statutory requirement to investigate and respond to complaints. This should never be put on hold without the complainant's permission. Where possible, and if the complainant agrees, the complaint investigation and patient safety incident investigation should be combined so that the patient/family get all the answers they are seeking together. Note, however, that the complaint may not limit itself to learning issues. When it is not possible to combine the two responses, how communication with those affected is best managed needs to be considered (see also [PHSO Complaints Standards Framework](#)).

Fitness to practise

Although the investigation's purpose is not to establish blame, it may establish facts that make a referral to a professional regulator appropriate. The [Just Culture Guide](#) can be

used by Human Resources to help make such decisions. The patient/family may themselves refer healthcare professionals to a regulator or a regulator may launch its own investigation. If a patient/family makes such a referral, or considers doing so, this must not alter the way they are engaged with and supported.

Health and Safety Executive

The Health and Safety Executive (HSE) investigates certain reportable injuries, diseases, and dangerous occurrences with a view to improving health and safety standards. Engagement leads should make families and staff aware of any such investigation and provide them with the relevant contacts.

Healthcare Safety Investigation Branch

Certain maternity incidents are required to be reported to the Healthcare Safety Investigation Branch (HSIB) and in future to the Special Health Authority. While upholding the Duty of Candour remains the trust's obligation, involvement in the investigation is led by HSIB.

Other patient safety incidents may be referred to HSIB where a national investigation has been requested. National investigations may happen alongside or after a local investigation has been completed; they do not replace local investigations. If local and national investigations are ongoing at the same time, organisations should work with HSIB to ensure involvement is coordinated in a way that is not burdensome and meets the needs of those affected.

Coroner's inquests

Engagement leads should ensure those affected are aware if there is to be a coroner's inquest and give them information about what this will entail.

Litigation

The investigation and resulting report should not be influenced by fear of litigation or reputational risk and must be compatible with the Duty of Candour. Lawyers should advise only on the legality of the report (eg statutory obligations). A patient's/family's decision to make a claim or consider making a claim should not alter the way they are engaged with and supported.

NHS Resolution

NHS Resolution provides expertise to the NHS on resolving concerns and disputes fairly, sharing learning for improvement and preserving resources for patient care. NHS Resolution may be involved at an early stage following some types of incident (eg maternity incidents reportable to the [Early Notification Scheme](#)), incidents reportable to Clinical Negligence Scheme for Trusts (CNST) and some inquest cases.

Families and staff affected should be informed of involvement of NHS Resolution.

Police investigations

Where a police investigation has already started, the engagement lead should discuss the purpose of a PSII with the police and how a police investigation and learning response can run in parallel wherever possible.

Families and staff affected by the incident should be informed of any delays to a learning response starting.

Social services

Investigations involving adult or child social services may be running while a patient safety response is ongoing. Again, the patient, family and staff members must be made aware of the investigation and the impact on them of being involved in both must be considered.

Media involvement

Some cases may attract local or national media attention due to the individual circumstances or place where the incident occurred. Some families may approach the media as they wish to share their story or to campaign. The trust communications team should be notified of any cases the media is covering or interested in.

Families may also post on social media, and it is important that staff do not engage with families via this method. Staff should be aware of and follow their organisation's social media policy. They must not reveal confidential information about any investigation or family, including any information that could be used to reveal the identity of another person.

Working with representatives and no responses

Working with representatives and indirect communication

If families or staff do not wish to be contacted directly to discuss a patient safety incident, thought should be given to how information can be shared with them. With the agreement of those affected, representatives, eg individuals providing bereavement services or ongoing care, could act as an intermediary, including for communicating responses to questions those affected may have, updates on the progress of an investigation, and to request checking of the draft report factual accuracy.

Through an enduring power of attorney, a person may be authorised to act on someone else's behalf. Where this is the case it should be the holder of the Power of Attorney who is engaged. Where no such person exists, patients with cognitive impairment should as far as possible receive communications directly, although the engagement lead may act in the patient's best interest in deciding who the appropriate person is to discuss incident information with.

An advocate with appropriate skills, and independent where possible, should be available to the patient to assist in the communication process.

No responses

If attempts to contact family or staff are unsuccessful:

- check the contact details used are correct and current
- consider alternate routes of contact
- review the communication that has been attempted to ensure it was appropriate for any possible needs of the recipient
- check informed choices have been given about the involvement opportunities.

If there is no response after repeated attempts to contact families and the above points have been considered, make a record of all the attempts, and continue the learning response without the involvement of the people affected.

Glossary

Advocate: An individual speaking on behalf of an individual affected by a patient safety incident, and/or supporting them to speak for themselves when they can.

Engagement: Engagement in this guidance refers to the prompt, effective liaison between persons affected by a patient safety incident and the organisation; this is done respectfully and according to individual needs.

Family: Family refers to the person or patient (the individual) to whom the patient safety incident occurred, their family and close relationships. Family and close relations may include parents, partners, siblings, children, guardians, carers, and others who had a direct and close relationship with the individual to whom the incident happened.

Family liaison officer (FLO): A role employed locally by trusts to support patients and families through the process of an investigation into a patient safety incident, or a serious complaint against a service provided by the trust.

May also be called family liaison and support officer (FLSO) or patient and family liaison officer (PFLO).

Involvement: The process of being involved in a learning response.

Learning response: Any response to a patient safety incident that incorporates a system-based approach to capturing learning to inform safety actions for improvement. This may be a patient safety incident investigation, but other methods can be used such as multidisciplinary team debriefs, huddles and after-action reviews.

Engagement lead: The person who leads engagement and involvement of those affected by a patient safety incident. Organisations may differ in how they approach engagement – this activity may be led by the person leading the learning response or by a family liaison officer (or similar). In this document, we use the term engagement lead to capture both possibilities.

Patient safety incident investigation (PSII): A system-based response to a patient safety incident for learning and improvement. Typically, a PSII includes four phases: planning, information gathering, synthesis, and interpreting and improving.

Staff: Defined as anyone charged with carrying out the work of the NHS or sometimes on behalf of the NHS (ie working for, employed by or contracted to the NHS).

Support: Assistance or comfort, which aims to assist people in coping with a variety of issues, according to their individual needs. In the context of patient safety incidents, support may be for physical, psychological or information and advice or advocacy needs. Support can be provided directly by the healthcare provider; by the person's own family, friends, or networks; or by independent organisations or individuals specialising in different forms of support.

Useful resources and references

[Behavioural insights into patient motivation to make a claim for clinical negligence \(NHS Resolution, 2018\)](#)

[Being Fair \(NHS Resolution, 2019\)](#)

[Being Open \(NPSA, 2009\)](#)

[Duty of candour animation \(NHS Resolution, 2022\)](#)

[Each Baby Counts: 2019 progress report \(Royal College of Obstetricians and Gynaecologists, 2020\)](#)

[Each Baby Counts: 2020 progress report \(Royal College of Obstetricians and Gynaecologists, 2021\)](#)

[Framework for involving patients in patient safety \(NHS, June 2021\)](#)

[Findings, conclusions and essential actions from the independent review of maternity services at The Shrewsbury and Telford Hospital NHS Trust \(Ockenden, 2022\)](#)

[Giving Families a voice: HSIB's approach to patient and family engagement during investigations \(HSIB, 2020\)](#)

[Harmed patient pathway \(AvMA and Harmed Patients Alliance, 2022\)](#)

[How to make an apology \(Scottish Public Services Ombudsman, 2020\)](#)

[Independent review of deaths of people with a learning disability or mental health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015 \(Mazars LLP, 2015\)](#)

[Learning, candour and accountability A review of the way NHS trusts review and investigate the deaths of patients in England \(Care Quality Commission, 2016\)](#)

[Learning from deaths: A review of the first year of NHS trusts implementing the national guidance \(Care Quality Commission, 2019\)](#)

[Learning from deaths: case studies from trusts \(NHS Improvement, 2017\)](#)

[Learning from deaths: Guidance for NHS trusts on working with bereaved families and carers \(National Quality Board, 2018\)](#)

[Learning from suicide related claims: A thematic review of NHS Resolution data \(NHS Resolution, 2018\)](#)

[National guidance on learning from deaths: A framework for NHS trusts and NHS foundation trusts on identifying, reporting, investigating, and learning from deaths in care \(National Quality Board, 2017\)](#)

[Regulation 20: Duty of candour \(Care Quality Commission\)](#)

[Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry \(Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013\)](#)

[Saying Sorry \(NHS Resolution, 2018\)](#)

[Support for staff following patient safety incidents \(HSIB, 2021\)](#)

[The early notification scheme progress report \(NHS Resolution, 2019\)](#)

[The future of NHS patient safety investigation: engagement feedback \(NHS Improvement, 2018\)](#)

[The NHS Patient Safety Strategy \(NHS Improvement, 2019\)](#)

Appendix: Example survey questions for seeking feedback

The scale of strongly agree, agree, disagree, strongly disagree and not relevant to my situation should be used.

For engagement:

- I was informed at the earliest opportunity about the patient safety incident I was involved in.
- I was given details of a specific individual and how and when I could contact them.
- The engagement lead showed flexibility in their approach towards me.
- I was treated with respect.
- I felt supported and was given helpful guidance and information regarding additional support I required.
- I was given meaningful, truthful, and clear answers and information in response to all queries and concerns.
- Where my expectations were not met or I was not satisfied, I was given meaningful, truthful, and clear explanations for why this was not possible and my questions or challenges to the organisation never inhibited its efforts to engage with me.
- Support offered by translation/interpreting services was effective in helping me engage with engagement leads.

For patient safety incident investigations:

- Contact with the engagement lead enabled me to feel part of the investigation.
- The engagement lead kept me informed throughout the investigation as much as I wished to be.

- I was involved in determining the terms of reference for the investigation.
- I was involved in determining the timeframe for completion of the investigation.
- Other family members were included in the investigation in an appropriate way.
- I felt my perspective on what happened was considered as part of the investigation.
- I was given the opportunity to make comments on the draft report.
- I received a copy of the final report and was given the opportunity to make comments on it.

Contact us:
patientsafety.enquiries@nhs.net

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

This publication can be made available in a number of other formats on request.

© NHS England 2022

Publication approval reference: PAR1465