

Stroke Association

Patient Safety Incident Response Plan

Introduction

Our Patient Safety Incident Response plan sets out how we will respond to safety incidents for learning purposes and to improve safety. The plan will remain flexible and consider the specific circumstances in which safety issues and incidents occur and the needs of those affected. It is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents.

We will formally review our PSIRF policy annually to ensure our focus remains up to date and in line with best practice. Updated plans will be published on our website, replacing the previous version.

Our Life After Stroke Services

Every day in the UK another 240 people wake up to the catastrophic impact of a stroke.

Stroke support provides survivors, and people who care for them, with the tailored one-to-one support they need to face the long and gruelling journey to recovery. We listen to and learn about what matters most to each stroke survivor. We provide support that's right for them – from understanding diagnosis, rehab and emotional support, to practical help with everyday issues at home and at work.

Our Stroke Support Helpline is there as the constant voice of comfort and support throughout a stroke survivor's long and frightening recovery journey.

Defining our Patient Safety Profile

To define our patient safety profile for 2024/25, we consulted with representation from Health and Safety, Safeguarding, Locality Impact (teams delivering commissioned services), Product Team (with responsibility for product quality), Complaints, Legal and Governance, People Practices and Business Improvement.

Reviewed November 2025

We defined our safety risks and responses by considering the following:

- Incidents reported by Stroke Association staff on our accident, incident and near miss forms, safeguarding alert forms and the reporting of data incidents.
- Data and insight provided by subject matter leads across our directorates.
- Complaints received from stroke survivors and those affected by stroke.

To identify opportunities for learning we review insights from our safety incidents data at our national safety learning and improvement group. This involves staff with expertise in safeguarding, complaints, health and safety, information governance, people practices, quality improvement and contract compliance. To determine a proportionate and compassionate response, we consider all safety incidents and explore insights from our safety data to identify and consider areas requiring improvement.

National Requirements

All types of incidents requiring a specific response will be reviewed and acted on according to the suggested methods in national policies or regulations. Incidents that meet the nationally defined criteria for Patient Safety Incident Investigation (PSII) will be fully investigated.

Our data analysis 2024/2025 indicates that no incidents have met the Patient Safety Incident Investigation criteria. The support provided by our commissioned services is unlikely to result in high-risk incidents occurring and it is not anticipated that locally led Patient Safety Incident Investigations will be routinely required.

Safeguarding incidents

In line with our Adults and Children's Safeguarding Policies, in all cases where a child or adult is believed to have been abused or suffered neglect, or is at risk of such actions, we will share relevant information with appropriate professionals and agencies. In all such situations the protection of the child will take precedence over any other considerations.

We will refer to the Local Authority Safeguarding Lead as appropriate. We will contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any safeguarding reviews (and enquiries) as required by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards.

Local Focus

Incidents not meeting the Patient Safety Incident Investigation criteria will be reviewed using safety tools to enable a learning response. Lesser harm incidents, or where there is lower potential for learning, will be managed at a local level with ongoing thematic analysis taking place at our national safety learning and improvement group.

Where we identify an incident involving another organisation, or if we are approached by another organisation regarding an incident, we will work collaboratively to review and identify learning.

Tools we will use:

- Coordinated direct communication between relevant staff immediately after an incident, acting quickly to analyse what happened and decide how to reduce any immediate risks and how to respond.
- Immediate safety action
- Case record review
- Safety huddle
- Adopt the use of SEIPS investigation methodology
- Focus on system-wide issue identification
- Collaborative approaches
- Learning Responses or PSII will be undertaken when an incident or near-miss causes or has the potential to cause serious harm or death, or where a lower harm incident has significant potential for learning.

Safety incident type or issue	Planned response and methods	Anticipated improvement route
Health and Safety Accidents, Incidents and Near Misses Slips, trips, and falls Other accident, incident or near miss causing low to moderate harm that emerges as a reoccurring theme	• Locality based coordinated communication • Discussion with Health and Safety national team • Thematic analysis of ongoing safety risks • Continued monitoring of accident incident and near miss records to determine any emerging risks/issues, including under reporting and any breaches of the required time frame for reporting health and safety incidents • Where there is a potential for serious harm, we will carry out a learning response	• Local safety actions created • Inform ongoing improvement efforts • Feed into our national safety learning and improvement group
Accident incident or near miss causing severe harm or death whilst receiving our support	• Learning response or PSII where this meets national priority criteria	

Safeguarding incidents	• Locality based coordinated communication • Discussion with Safeguarding Lead • Liaison with external local safeguarding partners as appropriate • Thematic analysis of ongoing safety risks • Continued monitoring of safety incident records to determine any emerging risks/issues, including under reporting and any breaches of the required time frame for reporting safeguarding incidents • Where there is a potential for serious harm, we will carry out a learning response	• Local safety actions created • Inform ongoing improvement efforts • Feed into the national safety learning and improvement group
Incident causing severe harm/ death or death by suicide whilst receiving our support	• Learning response or PSII where this meets national priority criteria	

Data Incidents	• Confirm facts at local and national level • Thematic analysis of ongoing safety risks • Continued monitoring of incident recorded to determine any emerging risks/issues, including under reporting	• Inform ongoing improvement efforts • Feed into the national safety learning and improvement group
Complaints	• Locality based coordinated communication • Thematic analysis of ongoing safety risks • Ongoing dedicated project aiming to improve the complaints process, including alignment with NHS standards • Continued monitoring of complaints recorded to determine any emerging risks/issues, including under reporting of complaints	• Inform ongoing improvement efforts • Feed into the national safety learning and improvement group

Our areas for improvement

Training- what we want to achieve

For all commissioned service delivery staff working in locality Impact and the support line staff to have the knowledge, confidence, and skills to take appropriate action in line with our PSIRF policy. Staff to have an awareness and understanding of PSIRF and their individual responsibilities. Staff who have specific additional PSIRF responsibilities to be clear about their role and have the necessary knowledge, skills, and confidence to carry this out.

Progress

All staff in commissioned service delivery roles and those in our national support line have had access to the NHS England online PSIRF training modules relevant to their role. 87% staff have completed Level 1 PSIRF 'Essentials' and 63% staff have completed the Level 2 PSIRF 'Access to Practise' course. Staff with additional PSIRF responsibilities have also completed a more intensive accredited training package. The Systems Approach to Learning from Patient Safety Incidents course is mandated for all those carrying out learning responses and in oversight roles.

Involvement and Engagement- what we want to achieve

To understand the views of people involved in a safety incident and learn from their feedback. This includes stroke survivors, families, staff and volunteers. Using new approaches and tools provided as part of our training to enable us to get the perspective of those involved in a safety incident, to inform learning and improvement.

Progress

Our thinking on this aspect has continued to evolve in line with embedding our new ways of working. We have taken a 'take one, do one approach' and are learning about involvement and engagement looks like by getting close to the work. Following a recent serious incident, intrinsic to our learning response has included having one to one conversation with a stroke survivor and

his family, alongside staff involved. Ensuring they are treated with compassion, they have been able to be part of the process creating a psychological safe space for people to share what has happened. Engaging with those affected by the safety incident has substantially improved our understanding of what happened at the system level and has given us rich insights into how we may minimise the chances of this happening again.

Systems- what we want to achieve

To have an effective way of recording all safety incidents to enable monitoring, review, and comparison of all safety data. To have the systems and processes in place to integrate the four key principles of PSIRF. To include improved ways to record safety incidents as we upgrade our electronic case management system (CRM).

Progress

We have made improvements in how we capture safeguarding referrals to external agencies, by integrating our internal reporting mechanism into our electronic client case management platform (CRM). This streamlines the process for staff and enables the safeguarding team to access this information in a timelier way. We are now registered on the NHS England 'Learn from Patient Safety Events' (LFPSE) platform to record patient safety events. This means that our patient safety data can help inform wider improvements beyond our organisation.

The new CRM was launched last month. As part of this the safeguarding section was updated to make it more user friendly and to incorporate the information required for LFPSE reporting. The safeguarding information on CRM is providing us with timely information and has improved national oversight of safeguarding incidents, allowing us to begin to consider what themes and trends are emerging.

Culture- what we want to achieve

For our staff to feel supported and enabled to report safety incidents without fear of blame. This will be ongoing, and we will continually reinforce our no blame culture during our training, communications and our approach to mentoring and coaching

Reviewed November 2025

Progress

We have been working hard to ensure that all our commissioned service delivery teams and our staff in our national support line are familiar with PSIRF and how it applies to their daily work. We have held specific PSIRF webinars as well as talking about this in our everyday conversations. We have continued to build on our open culture so that everyone feels supported and able to report safety incidents without fear of blame. We have found that the most effective way to embed a 'no blame culture' is in experiencing PSIRF first hand. Operational staff that have been involved in learning responses have demonstrated a significant shift in their attitude towards the value the approach and demonstrated an increasing willingness to participate.

Acting on Learning- what we want to achieve

To contribute to national system learnings about patient safety incidents by entering safety incidents that occur in England, as part of the delivery of NHS funded services, into the Learn from Patient Safety Events (LFPSE) platform. To have systems and processes in place to agree, implement and monitor safety improvements using an integrated approach to reduce risk and limit the potential for reoccurrence.

Our national forums will monitor the implementation of these to ensure best practice. We will continually review the impact of improvements to evaluate their effectiveness. Our aim is to routinely share our learnings so that this becomes our 'usual way of working'.

Progress

NHS England Learn from Patient Safety Events (LFPSE)

We are currently working with our Safeguarding Lead and our Health, Safety and Workspace Business Partner testing mechanisms for the Coordinator Led Locality Support Products Team to input safety incidents onto LFPSE.

Where required we will comply with requests from Integrated Care Boards (England) or Health Boards (Wales and Northern Ireland) for input when a cross-system incident occurs.

Reviewed November 2025

Safety Learning and Improvement Group

Through our ongoing PSIRF work it became clear that safety underpins everything that we do. After careful consideration we decided to improve our existing national Beneficiary Quality Oversight Group and transform this into the Safety Learning and Improvement Group to review our safety data. The Safety Learning and Improvement Group held its first meeting in May 2025 and now has regular meetings. The group includes staff with specialist knowledge of health and safety, safeguarding, data Incidents, complaints, and our local service delivery. This space focuses on understanding what our data is telling us about safety incidents to make better decisions about where we make improvements.

This group is a dedicated national forum for continuous learning and incident data analysis and sense making. The focus is on recognising patterns and trends or serious incidents that may require us to take a closer look at our processes or consider working differently. These findings could spark a broader discussion or initiate a focused sprint to further understand the issue.

PSIRF is a regular agenda item at the meeting, where learning response findings are shared and discussed. We currently have three live learning responses in progress. These learning responses are following serious incidents which have occurred in commissioned services. We are learning in the everyday experience of completing the learning responses and are adapting the NHS learning response toolkit to ensure we have effective PSIRF processes and tools available to support staff in the future.

In the East of England, we were included in a 'Swarm Huddle' activity led by Basildon, Brentwood and Thurrock University Hospital Stroke Hub Team. This was a forum to provide support, guidance and feedback following a death by suicide by an individual who was being supported by a number of community services, including our Stroke Recovery Service. A report was produced and shared with the patients daughter. We have agreed to explore validated mood screening when there is a disclosure of low mood within the service. Our local service delivery team are working closely with the Stroke Hub Team to understand how this may benefit stroke survivors in receipt of our support.

Plans for further work

We have made great progress, but we know there is more to do. We want to continue to increase staff awareness of our safety culture to improve the reporting of safety incidents. We will continually review the impact of any improvements to our practices to evaluate their effectiveness. Our aim is to routinely share learnings so that this becomes our 'usual way of working.' We will continue to consider the opportunities that PSIRF presents to align some of our existing governance reporting mechanisms. This will enable us to work more effectively to ensure that improvements support stroke survivors, our staff and volunteers to live and work as safely as possible.

Key priorities for the next 12 months

- Review and update PSIRF Policy and Plan in response to external factors and any new learnings as a minimum annually
- Strengthen shared local accountability and curiosity when unexpected safety incidents occur
- Improve systems for comprehensive oversight of safety data
- Assess and consider additional training needs to continually improve safety
- Promote a consistent, open and transparent safety culture across all levels across the organisation
- Embed a no blame approach and improve communication to share learnings when unexpected things happen
- Translate learning response data insights into actionable safety improvements