Stroke Association
Patient Safety Incident Response Plan

Introduction

Our patient safety incident response plan sets out how we will respond to safety incidents over the next twelve months. The plan will remain flexible and consider the specific circumstances in which safety issues and incidents occur and the needs of those affected.

Our organisational values will support our safety culture to promote a consistent, constructive, and fair evaluation of the actions of staff involved in safety incidents.

Our Life After Stroke Services

Our commissioned services support people to rebuild their lives after stroke. The impact of stroke often lasts a lifetime, and we know that people's needs change over time. We believe everyone deserves to live the best life they can after stroke. Stroke can impact work, relationships, confidence, self-esteem, independence, financial position, decision-making abilities, housing needs, ability to drive and social life to name but a few. It is critical that people affected by stroke receive the support they need in the long-term to rebuild their lives and lead the best life possible.

Across the UK we deliver commissioned life after stroke services, offering meaningful support face-to-face, over the phone and online for thousands of people affected by stroke. We provide Stroke Recovery Services, Post Stroke Reviews, Communication Support Services and Emotional Support Services.

Our Stroke Recovery Service commences early in the pathway, and continues into the longer-term, acknowledging the person affected by stroke's need for ongoing care and support, and what is important to them, can change significantly over time.

Working in parallel with community stroke rehabilitation services, the Stroke Recovery Service provides a seamless experience of care for the person affected by stroke, where their needs are placed at the centre. Performing a unique, but complementary role focused on life after stroke which importantly starts immediately after stroke, rather than following rehab, to support the best possible recovery for individuals affected by stroke.

Defining our Patient Safety Profile

To define our patient safety profile, we formed a Patient Safety Incident Response Framework (PSIRF) Core Implementation Group. This group included 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.

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 breaches;
- Data and insight provided by subject matter leads across our directorates;
- Complaints received from stroke survivors and those affected by stroke.

We considered quantitative and qualitative data over a 5-year period 2018-2022 from across the organisation. Just over 2000 records have been reviewed to identify key themes and gaps.

In order to implement PSIRF we will establish an overarching PSIRF Learning Group, formed by staff with expertise in relevant areas including safeguarding, complaints, health and safety, information governance, people practices, quality improvement and contract compliance. To determine a proportionate and compassionate response, we will consider all safety incidents and explore insights from our safety data to identify and consider areas requiring improvement.

In the creation of this plan, we worked in partnership with Hertfordshire and West Essex Integrated Care Board Patient Safety Specialist.

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 (period 2018-2022) indicates that no incidents have met the Patient Safety Incident Investigation criteria. The support provided as part of 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 we 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 PSIRF Learning Group to inform improvements.

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.
- Patient Safety Incident Investigations; these 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.

Analysis of our safety data has highlighted the following areas for ongoing improvement. We are also committed to learning from positive care and will identify examples throughout the year.

Safety incident type or issue	Planned response and methods	Anticipated improvement route
Slips, trips, and falls	Locality based coordinated communication Thematic analysis of ongoing safety risks	Local safety actions created Inform ongoing improvement efforts Feed into the PSIRF Learning Group
Other accident, incident or near miss causing **moderate to low harm**	Locality based coordinated communication Thematic analysis of ongoing safety risks	Local safety actions created Inform ongoing improvement efforts Feed into the PSIRF Learning Group

Safeguarding 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	Locality based coordinated communication Thematic analysis of ongoing safety risks	Inform ongoing improvement efforts Feed into the PSIRF Learning Group
Data Breach Continued monitoring of incident recorded to determine any emerging risks/issues, including under reporting	Confirm facts at local and national level Thematic analysis of ongoing safety risks	Inform ongoing improvement efforts Feed into the PSIRF Learning Group
Complaint Continued monitoring of complaints recorded to determine any emerging risks/issues, including under reporting of complaints	Locality based coordinated communication Thematic analysis of ongoing safety risks	Inform ongoing improvement efforts Feed into the PSIRF Learning Group

Using NHS PSIRF guidance, tools and templates we produced a project plan, which included key milestones for us to achieve. We have taken a systematic approach to this work and began by spending time scoping and researching PSIRF requirements. We have sought external guidance and support, attended webinars and joined forums on the NHS Futures platform. We collated and reviewed our safety incident data over the last 5 years and completed a gap analysis. We cross referenced this against our existing safety systems and processes to identify what is working well and where we have opportunities to improve. The insights from this work have formed the basis of the priority areas for improvement that we have included in this plan.

Area for Improvement	What we want to achieve	What we will do	How we will do this	When
Training	All commissioned service delivery staff within the Locality Impact Directorate to have the knowledge, confidence, and skills to take appropriate action in line with our PSIRF policy.	Upskill relevant Locality Impact staff to have an awareness and understanding of PSIRF and their individual responsibilities. This includes the way we think about and approach safety incidents and being open to new ways of doing things.	NHS Patient Safety Syllabus Training Level 1 completed by all Locality Impact commissioned service delivery staff NHS Patient Safety Syllabus Training Level 2 completed by all Locality Impact commissioned service delivery staff (except administrators) Create new PSIRF awareness training specific to our approach, systems, and tools. Deliver this training to all relevant Locality Impact staff.	During April–September 2024 During April–September 2024 New training modules ready to be delivered from December 2024
	All 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.	Upskill all staff who have additional PSIRF responsibilities.	All staff with additional PSIRF responsibilities to complete NHS PSIRF Training National Syllabus Level 1, 2 and Level 3 accredited courses.	During April - September 2024

Engagement	To understand the views of people involved in a safety incident and learn from their feedback to make ongoing improvements. This includes patients, families, staff and volunteers.	We will have an agreed way of involving people affected by a safety incident at every stage from the time we are aware of this until an outcome is achieved.	Begin to trial new approaches and tools to enable those involved in a safety incident to be heard to inform improvements.	September – December 2024
Systems	To have an effective way of recording all safety incidents in one place to enable monitoring, review, and comparison of all safety data.	To have a unified mechanism in place to enable the consistent recording of all safety incidents.	Explore the possible options to enable electronic capture of all PSIRF incidents and plan trial of new systems.	April – September 2024
Involvement	To have the perspective and understanding of those affected by stroke to make meaningful improvements.	To include people affected by stroke when reviewing insights from safety data.	We will involve those affected by stroke to ensure their voice of lived experience is heard and the expertise of people affected by stroke shapes our decisions.	Ongoing
Culture	For our staff to feel supported and enabled to report safety incidents without fear of blame.	Increase staff awareness of our safety culture to improve the reporting of safety incidents.	We will reinforce our no blame culture during our training, communications and our approach to mentoring and coaching.	Ongoing

Acting on Learning	To contribute to national wider system learnings about patient safety incidents. To strive for ongoing improvements to keep our staff, volunteers, and those we provide support to as safe as possible.	Enter our safety incidents that occur in England into the Learn From Patient Safety Events (LFPSE) platform. We will use the information that we capture about all safety incidents to spot patterns and trends to be able to make improvements to reduce the likelihood of the same thing happening again.	We will register our organisation onto the LFPSE platform. We will determine the requirements of the LFPSE platform and agree our internal mechanisms to do this. We will establish a process to continually review the impact of improvements to evaluate their effectiveness	April – September 2024 Ongoing