TIAN

The Internal Audit Network

PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK BENCHMARKING

AUGUST 2025

Introduction

The Patient Safety Incident Response Framework (PSIRF) was published in August 2022 alongside a preparation guide that articulates a phased approach to transition. The PSIRF fundamentally shifts how the NHS responds to patient safety incidents for learning and improvement.

PSIRF:

- advocates a co-ordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected by patient safety incidents
- embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management

It supports the introduction of a range of system-based approaches to learning, with considered and proportionate responses to patient safety incidents and thematic reviews being undertaken to develop a safety improvement plan.

This represents a significant cultural shift in patient safety incident management with the aim of embedding sustainable change and improvement across organisations.

A questionnaire benchmarking exercise has been undertaken across The Internal Audit Network (TIAN) organisations to understand progress on the implementation of PSIRF, identify common areas of difficulties and share any good practice (see page 8 for information about TIAN).

The TIAN organisations involved were 360 Assurance, MIAA, Audit Yorkshire, Audit One, Barts Assurance and ASW Assurance.

Summary of findings

59 individual organisations participated in the exercise which included four Integrated Care Boards (ICBs) and 55 provider Trusts. A set of questions were provided to each organisation and the findings were collated and analysed. All of the organisations had launched PSIRF between April 2023 and March 2025, three of which were early adopters.

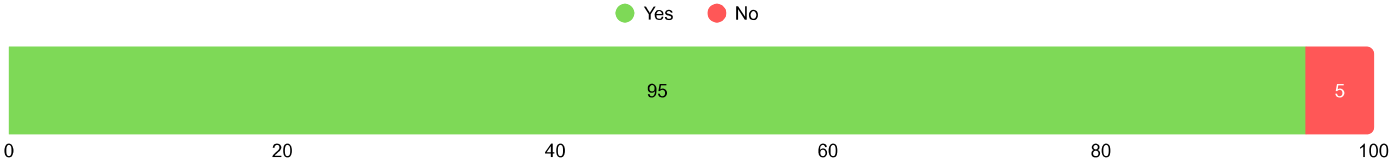
The detailed results against each question are shown from page three onwards, which are summarised below:

- Whilst all provider trusts had a PSIRF plan in place, 27% of these had not yet been signed off by the relevant ICB.
- 92% of provider trusts had a PSIRF policy in place, although 38% of these not yet been signed off by the relevant ICB.
- Less than half of organisations responded positively that they had assessed capacity and capability to effectively deliver the patient safety incident response plan.
- 15% of organisations did not align the patient safety incident response plan to the patient safety risks identified by the organisation and less than half to any safety risks identified in the Corporate Risk Register.
- One third recognised more was required to brief the Board on PSIRF and 12% had not appointed an Executive lead.
- Around two thirds had implemented the guidance on Patient Safety Specialists.
- A large number of comments were received around steps taken and direction of travel to define and embed shared learning (see pages 5 and 6).
- One third acknowledged there was more to do to engage with the system to develop system wide relationships to support the implementation of PSIRF.

- One third did not have a formal training needs assessment but various comments were received on the approach to identification and delivery of training (see page 7).
- One third acknowledged there is more to do to engage with those affected by patient safety incidents to agree the timeliness of responses. Some good practice comments are noted (see page 7).
- One third noted the processes to monitor the implementation of safety actions as being 'partial'.

Detailed Responses

Does the organisation have a PSIRF Plan?



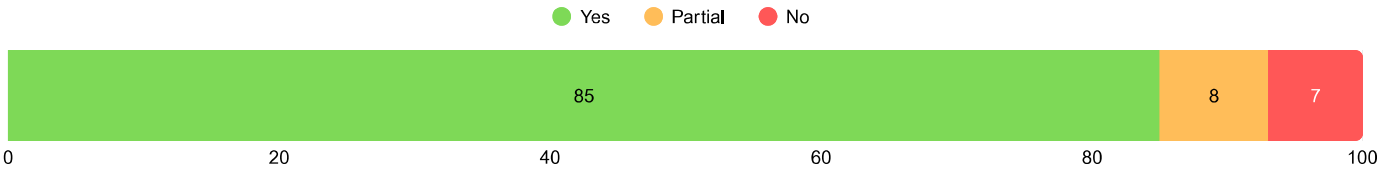
Comments:

- All three organisations who responded 'No' were ICBs.

Good practice points:

- Good practice documents cited were Patient Safety and Quality Strategies, a PSIRF Patient Engagement Communication Document and a PSIRF Engagement Handbook.

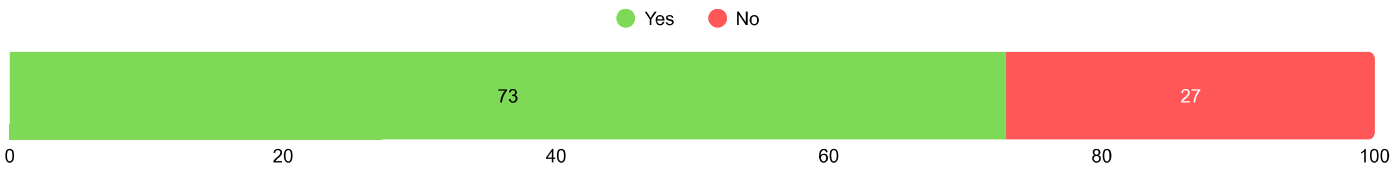
Has the PSIRF Plan been published?



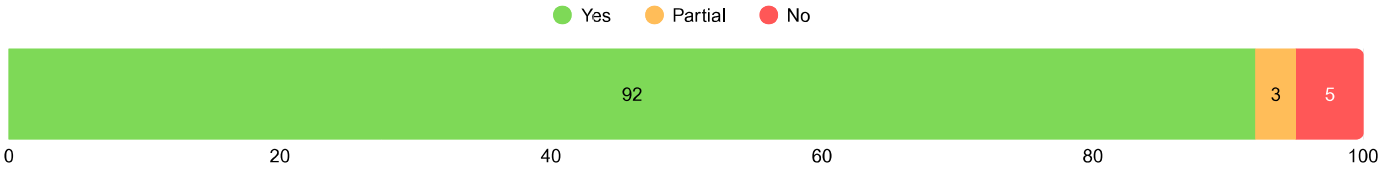
Comments:

- 3 of 4 organisations who responded 'No' were ICBs with no plan in place.

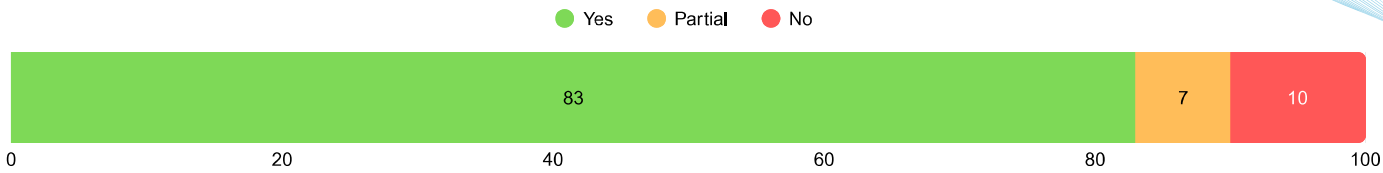
Has the PSIRF Plan been signed off by ICB?



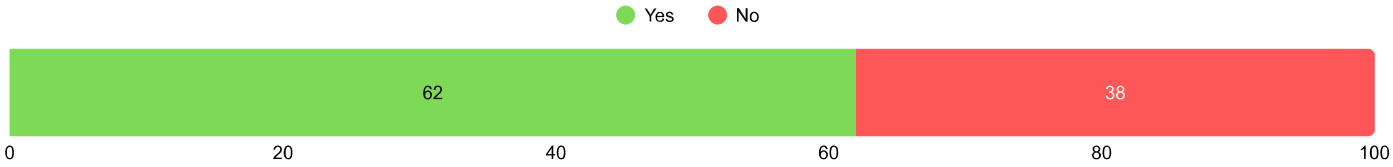
Does the organisation have a PSIRF Policy?



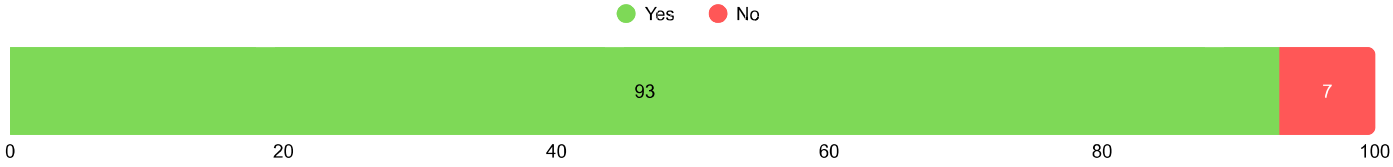
Has the PSIRF Policy been published?



Has the PSIRF Policy been signed off by ICB?



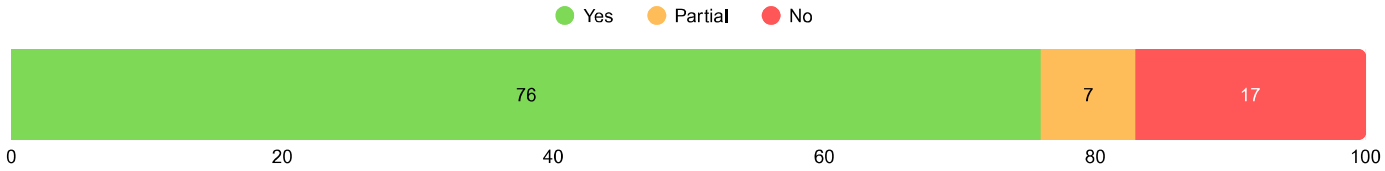
Does the PSIRF Plan demonstrate a thorough analysis of the data collated and provide a clear rationale for the selection of patient safety incidents for further learning?



Comments:

- Those organisations who responded 'No' did not have a Plan in place.

Has the organisation assessed its capacity and capability to effectively deliver its patient safety incident response plan?



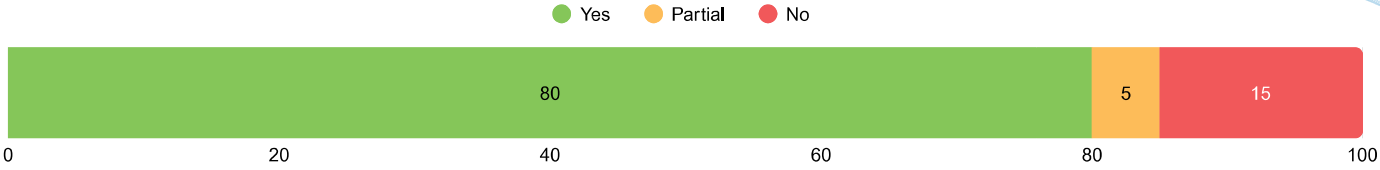
Comments:

- Percentage is based on answers received with 30 organisations not providing an answer.

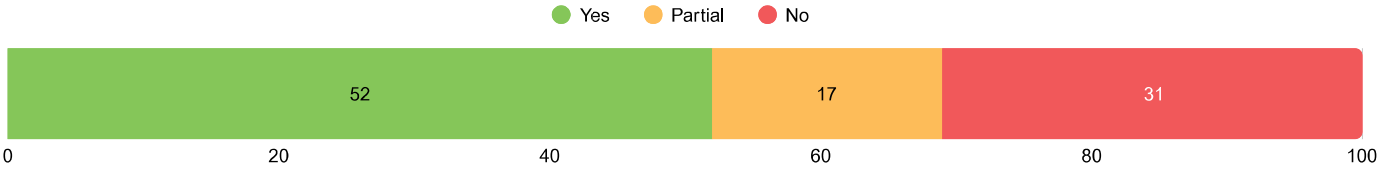
Good practice points:

- List of subject matter experts in place.
- PSIRF Training Needs Analysis (TNA) and Key Performance Indicators (KPIs) which are monitored by a relevant Committee.
- Integration of Quality Improvement, Investigation and Engagement into a single team.

Does the patient safety incident response plan align to the patient safety risks identified by the organisation?



Does the PSIRF Plan align to risks on the Corporate Risk Register?



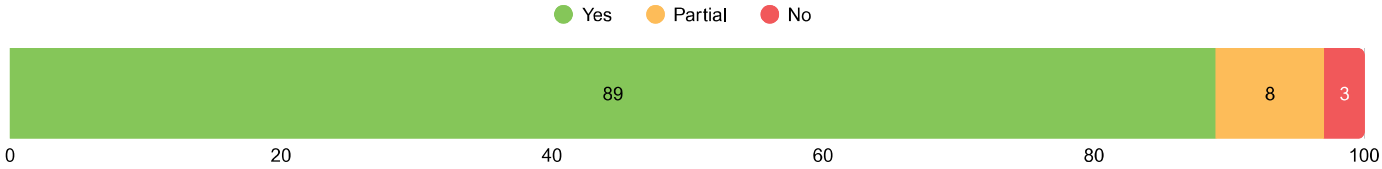
Comments:

- Percentage is based on answers received with 30 organisations not providing an answer.

Good practice points:

- Assurance on the embedding of PSIRF is also tracked and monitored through the Board Assurance Framework.

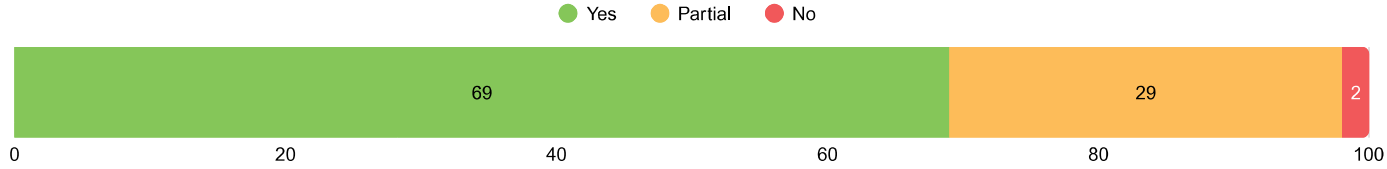
Is the governance and sign off process for Patient Safety Incident Investigations (PSII) clear?



Good practice points:

- A formal monitoring mechanism to ensure that Engagement Leads and Learning Response Leads contribute to two or more responses per year. Thereby, ensuring that skills and knowledge for staff is up to date.

Has the Board developed its understanding on PSIRF and the changes this brings?



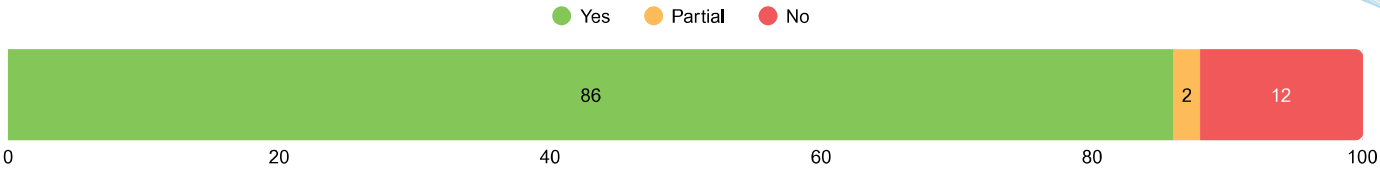
Comments:

- Partial responses related to Boards whom had been adequately briefed, but relevant sub-committees have yet to formally assess their PSIRF assurance requirements.

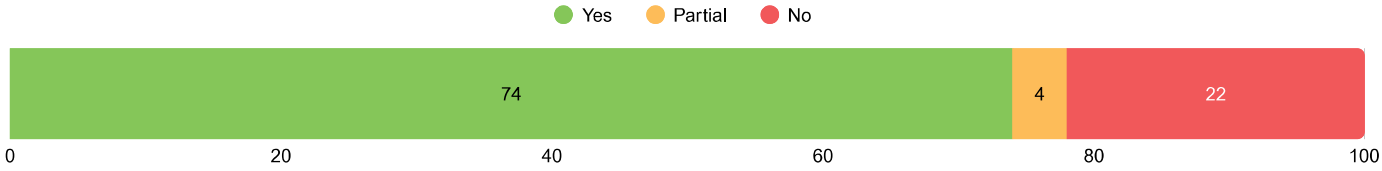
Good practice points:

- Robust governance structures in place with a reporting structure up to Board.
- Assurance on the embedding of PSIRF is also tracked and monitored through the Board Assurance Framework (BAF).
- PSIRF TNA and KPI's which are monitored by a relevant Committee.
- The appointment of an external company to deliver a board seminar training for PSIRF oversight.

Has the board identified an Executive responsible for PSIRF?



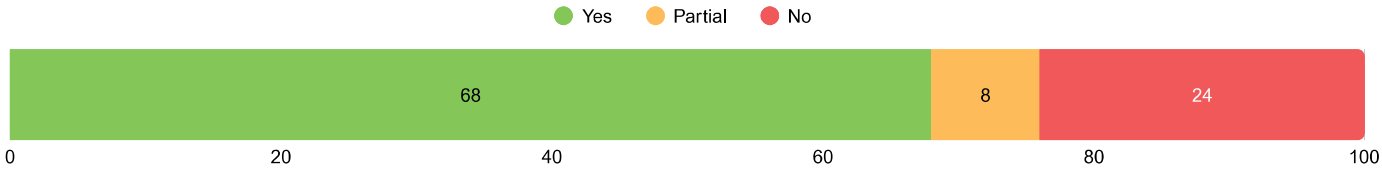
Has the organisation assessed itself against the PSIRF standards?



Comments:

- Percentage based on answers received with 8 not providing an answer

Has the organisation implemented the guidance on Patient Safety Specialists?



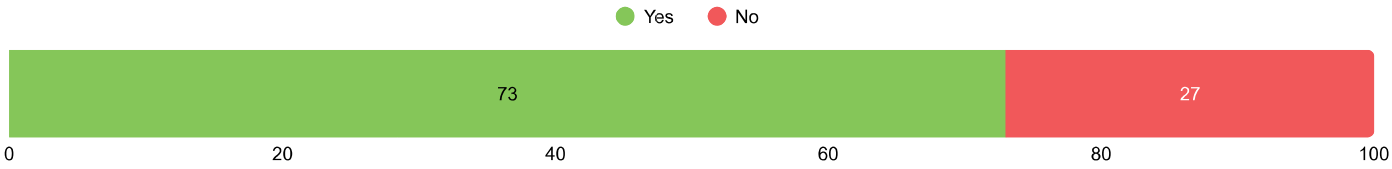
Comments:

- The organisation has assessed the need for Patient Safety Partners (PSPs) and has designed a policy but has yet to employ any PSPs.

Good practice points:

- The Trust has chosen to recruit as many Patient Safety Partners as possible, with the intention of allocating them to work areas according to their preference, so that they can develop relationships with divisional risk and governance leads and become embedded in their teams.

Has the organisation defined how it will share learning?



Partial scores relate to comments received:

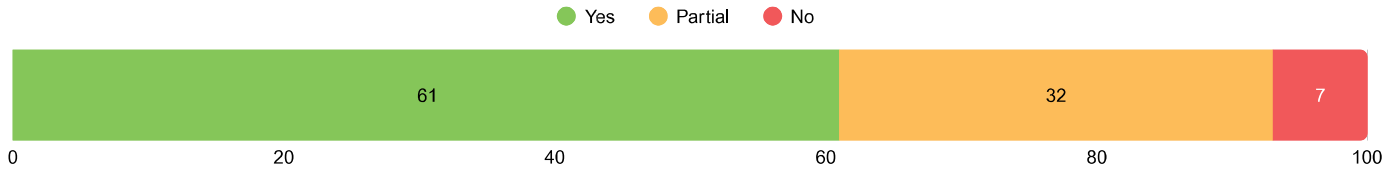
- Learning from actions being shared inconsistently.
- Learning is not embedded.

- Trust staff should be encouraged to always document the response to all incidents, even if as simple as noting that the incident was discussed at Safety Huddle and no action or learning was identified. This would enable the Trust to have greater assurance that all incidents have received an appropriate response.
- Although the PSIRF policy describes sharing learning, it does not specify how learning will be shared across the organisation, nor the different formats or methods for sharing this information. It also lacks clear expectations and staff on the ground have not been involved in designing the methods for sharing.
- There are processes in place but these need to be reviewed and staff need to provide feedback on their operation and suggest improvements.

'Yes' reply comments stated:

- The organisation is progressing with embedding learning through a Sustained Learning Group (SLG), strengthened by the development of a terms of reference.
- Continuing to embed learning through a Shared Learning Forum.
- The organisation shared learning through several mechanisms including daily huddles, learning improvement bulletins, and divisional meetings. Learning is also highlighted in the Patient Safety Quarterly report through key themes and actions and shared through the governance reporting structure.
- The organisation's Always Safety First Learning Group demonstrated a broad consideration of the application of learning from incidents and its role in effective dissemination both targeted and Trust-wide. There was consideration of PSIRF input but also other sources of patient safety intelligence and risk national and local, such as central alerts, results of national inpatient survey, other Trust groups such as medicines management and infection prevention and control, and clinical audit.
- National patient safety updates included in Allied Health Professionals and Nursing webinar for embedding PSIRF in maternity services. Also, a National Patient Safety Alert (NatPSA) and an update on World Patient Safety Day (a blog) was published.
- Thematic analysis and a hierarchy of control is used to analyse incidents and improvement actions
- Trust's Learning from deaths programme with partner university.

Has the organisation defined how it will share learning?



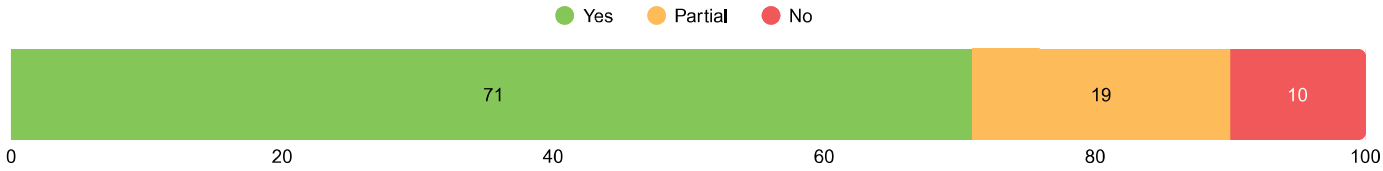
Comments:

- The organisation is liaising with the system and the ICB; however, system learning and sharing still need to be fully embedded, and the infrastructure for ICB oversight requires implementation.

Good practice points:

- Good example of how Patient Safety Incident Investigations (PSIIs) can be done across the system and how the ICB will operationally implement PSIRF.
- The organisation facilitated extensive in person events such as 121 sessions covering all key areas of the organisation.
- Meetings with ICB and partner organisations as well as coronial process.

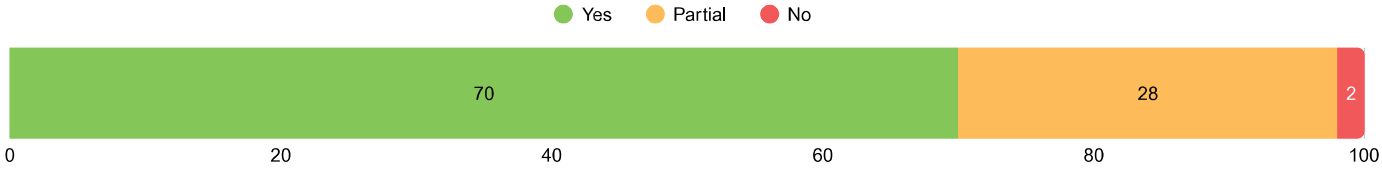
Is there a training needs analysis for PSIRF, which includes training for individual roles and competencies?



Good practice points:

- No specific training needs analysis completed but updated PSIRF training done for all levels for staff who undertook previous investigations and for new people identified by managers who will now undertake them.
- There was a comprehensive training in place for PSIRF level 1, level 2 and level 3 with compliance monitoring at divisional level through to Trust Board.
- Rolled out Patient Safety Training Level 1 & 2 across the organisation and had over 80% compliance within 6 months.
- The Trust continues to develop PSIRF with the support of the wider governance team in identifying quality priorities, the introduction of Systems Engineering Initiative for Patient Safety (SEIPS) into Quality Improvement training.
- Teams Live Briefings to all staff on Vimeo in July 2022 - Patient safety, a Just Culture and PSIRF Update.
- PSIRF TNA and KPI's which are monitored by a relevant Committee.
- Training package for After Action Review (AAR) conductors and development programme.
- Trust's Behaviour Framework.
- Short film featuring a family members experiences.
- PSIRP the sequel presentation/video.
- The Trust facilitated extensive in person events such as 121 sessions covering all key areas of the organisation.

Is the organisation engaging with those affected by patient safety incidents to agree the timeliness of responses?



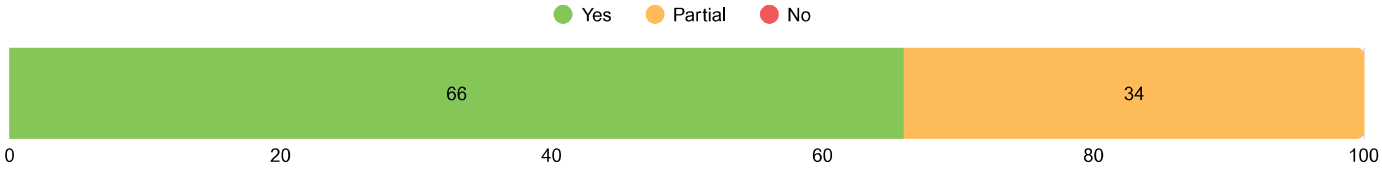
Comments:

- Engagement with patient / family identified but does not confirm if timescales for response is agreed.
- Inconsistent processes followed for incidents.
- Incidents were not always closed in a timely manner on InPhase.
- There was also lack of evidence to confirm how patients/family/carers had been engaged in these reviews beyond duty of candour.
- Not able to demonstrate engaging with those affected by patient safety incidents to agree the timeliness of responses.

Good practice points:

- Families are given PSII drafts to review and are invited to contribute to the development of safety actions.
- Utilise a PSIRF patient pamphlet which refers to the named contact that can provide information about types of support, such as counselling and bereavement services as well as independent advocacy services.
- Wellbeing Service which co-ordinates support and logs referrals/contacts.
- Investigating Officer Checklist for Communication with Patients and Families.
- eBook for supporting patients, families, and staff after an incident.

Are there processes in place to monitor the implementation of safety actions?



Good practice points:

- There is a process in place to monitor the implementation of safety actions through the Risk Management System. However, there is no guidance on abandoning safety actions and using methodology such as iFaces to prioritise actions.
- Utilisation of specific System Improvement Plans for oversight.
- Trust's Learning from deaths programme with partner university.
- Integration of Quality Improvement, Investigation and Engagement into a single team.

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