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To:
- NHS trust and foundation trust:
  - Chief executives
  - Medical directors
  - Nursing directors
- Integrated Care Board:
  - Medical directors
  - Nursing directors
- NHS England Regional Team:
  - Medical directors
  - Nursing directors
- NHS England regional direct commissioning leads

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Dear Colleague,

Introduction of the Patient Safety Incident Response Framework

I am pleased to inform you that today we have published the Patient Safety Incident Response Framework (PSIRF), representing a significant shift in the way the NHS responds to patient safety incidents. This is a major component of the NHS Patient Safety Strategy that sits alongside the wider NHS Long Term Plan. The PSIRF will replace the Serious Incident Framework (SIF) that has been in place since 2015.

The introduction of PSIRF is a major step towards improving safety management across the healthcare system in England and will greatly support the NHS to embed the key principles of a patient safety culture.

PSIRF was tested in 17 early adopter organisations, alongside CCGs and NHSE regional patient safety leads. An independent evaluation of the early adopter programme found that it is a better way forward. The framework promotes a more proportionate and considered response to patient safety incidents focusing on how they happen, rather than apportioning blame on individuals. This ‘systems thinking’ approach enables more effective learning and improvement, ultimately making NHS care safer for our patients.

The PSIRF supports organisations to harness their resources for patient safety investigation in the most effective way and introduces a range of national tools and templates to support learning and improvement. PSIRF makes the leaders of provider organisations accountable for high quality incident responses while Integrated Care Boards (ICBs) will consider their providers’ overall approach rather than each individual

response. Alongside the framework, we have also published a 'Guide to engaging and involving patients, families and staff following a patient safety incident' setting out expectations for how those affected by an incident should be treated with compassion and involved in any investigation process. Listening to those affected by an incident is not only the right thing to do, it also provides vital insight to help make care safer.

The transition to PSIRF from the SIF will necessarily be a gradual process that we expect to take around 12 months. I ask your organisation to begin this process from September onwards with the aim of completing the transition by Autumn 2023.

To support PSIRF implementation, we have commissioned our Patient Safety Collaboratives to facilitate preparation to transition and published a range of supporting information and resources both on the NHS England website and our FutureNHS workspace. This includes an introductory animation setting out the key principles of PSIRF, and videos from our PSIRF early adopters. We will also be hosting a series of webinars, the first of which is on Monday 5 September 2022. You can register here.

A key part of the preparation for PSIRF will be a review of your current systems and processes against the new patient safety incident response standards. This will determine where effort should be maintained and where adaptations are required.

Organisations are also required to develop and publish their own patient safety incident response policy and plan. Developing this plan will include establishing your local patient safety incident profile and reviewing your existing improvement work. This will help inform how you plan to maximise opportunities for learning and improvement in the areas where patients will benefit the most.

Trust boards are asked to identify a PSIRF executive lead to support the responsibilities outlined in our Oversight roles and responsibilities specification. The PSIRF executive lead may be the person with overarching responsibility for quality or patient safety. ICBs and NHS England regional teams will also appoint an appropriate lead to support PSIRF responsibilities.

Finally, I'd like to thank our early adopters who have been testing the introductory version of PSIRF in their organisations since March 2020, and whose experiences and feedback have been instrumental in shaping the final version of the framework.

Yours sincerely,

Dr Aidan Fowler
National Director of Patient Safety in England
NHS England