



HEALTHCARE RIGHTS, COMMUNICATION & PATIENT SAFETY

PSIRF

Patient Safety Incident Response Framework
Learning and improving after patient safety incidents

The key idea

PSIRF is the NHS approach in England for responding to patient safety incidents for learning and improvement. It moves away from treating every incident through the same investigation route and instead promotes compassionate, system-based and proportionate responses.

What is PSIRF?

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS approach to developing and maintaining systems for responding to patient safety incidents for the purpose of learning and improving patient safety. A patient safety incident is an unintended or unexpected event, including an omission, in healthcare that could have harmed or did harm one or more patients.

In everyday language

When something goes wrong — or nearly goes wrong — PSIRF asks organisations to understand how and why it happened, involve the people affected and use that learning to make care safer.

What changed under PSIRF?

PSIRF replaced the former Serious Incident Framework. It removed the old 'Serious Incident' classification and threshold. Rather than automatically linking the perceived seriousness of an outcome to one particular investigation process, PSIRF promotes a considered and proportionate response based on the potential for learning and improvement.

Key distinction

Proportionate does not mean unimportant incidents are ignored. It means the type of learning response should fit the incident, the risks and the learning opportunity. Resources should be used where they can best support meaningful improvement.

The four central aims

PSIRF brings together four aims: compassionate engagement and involvement of people affected by incidents; system-based approaches to learning; considered and proportionate responses; and supportive oversight focused on strengthening the incident-response system and improvement.

Compassionate engagement

Patients, families, carers and staff affected by an incident should be treated with compassion and given opportunities to be involved. NHS England guidance expects organisations to work to answer people's questions and, with agreement, involve them in learning responses.

What this might look like

A family affected by an incident is offered a named contact, asked what questions they want the learning response to explore, kept updated and invited to contribute their perspective. Their involvement is planned around their needs rather than treating them only as a source of evidence.

Learning about systems, not simply finding an individual to blame

PSIRF promotes systems thinking. Incidents often arise from interactions between people, tasks, equipment, environments, processes and organisational conditions. Learning responses explore these contributory factors so that improvement is not reduced to telling one person to 'be more careful'.

Different ways to learn

A full Patient Safety Incident Investigation (PSII) is one learning-response method, but it is not the only one. NHS England's toolkit includes approaches such as After Action Review, Swarm Huddles, multidisciplinary team review and thematic or aggregate analysis. The method chosen should suit the question the organisation needs to understand.

Important to know

Not every reported patient safety incident will receive a full PSII. PSIRF deliberately supports different forms of learning response. Some nationally defined events still require a PSII, while organisations also identify local priorities through their incident-response planning.

Patient safety incident response policy and plan

Providers are expected to maintain a patient safety incident response policy describing their systems and processes, alongside a response plan setting out their patient-safety incident profile and how they intend to respond to priorities for learning and improvement. These should reflect national requirements and local information.

What does 'proportionate' mean?

A proportionate response considers what happened, what is already known, the potential for new learning, ongoing risk, national requirements and how best to use available safety resources. The goal is not simply to produce an investigation report; it is to generate useful insight and support improvement.

Key distinction

PSIRF is primarily a framework for learning and improvement. It does not replace other processes that may be needed after an incident, such as the statutory duty of candour, safeguarding, complaints, professional regulation, coronial processes or legal claims.

Duty of candour still applies

Where an incident meets the legal criteria for a notifiable safety incident, the statutory duty of candour applies independently of the learning response selected under PSIRF. The organisation's responsibility to be open and transparent is therefore not removed because it chooses a response other than a full investigation.

What can patients and families ask?

People affected by an incident can ask what response is being undertaken, how that response was chosen, who their contact is, how they can contribute, what questions the organisation is seeking to answer, how they will be kept updated and how learning will be turned into improvement.

Practical question

If you expected a full investigation but another response has been chosen, ask the organisation to explain the rationale, how your questions will be considered and what process will be used to identify and act on learning.

Who must use PSIRF?

PSIRF is a contractual requirement for healthcare provided under the NHS Standard Contract, including acute, ambulance, mental health, community, maternity and specialised services. Its principles also apply to NHS-funded healthcare under that contract when delivered by non-NHS organisations. NHS England reported in July 2026 that PSIRF had been implemented in every NHS secondary-care provider since 2024.

What about primary care?

Primary care is at a different stage of implementation. NHS England's July 2026 patient-safety update reported PSIRF pilots in more than 200 GP practices, with wider primary-care scoping planned for 2027. Earlier national guidance also supports proportionate implementation approaches in general practice and other primary-care services.

Important to know

Do not assume that the exact same local PSIRF process applies in every GP, dental, pharmacy or optometry setting. Ask the organisation or integrated care board what patient-safety incident response arrangements currently apply.

Supportive oversight and safety culture

PSIRF oversight is intended to focus on whether the response system is functioning well and leading to improvement, rather than relying only on policing individual investigations. This sits alongside a wider patient-safety culture that encourages reporting, fairness, transparency and learning.

For professionals

Current PSIRF standards cover policy, planning and oversight; competence and capacity; engagement and involvement of those affected; and proportionate responses. Organisations should ensure people undertaking and overseeing learning responses have appropriate training, time and support.

Practical check

Has the organisation explained what response is being used and why? Have patients, families and staff affected been offered compassionate engagement? Is the response looking at system factors? Is there a route from learning to improvement? Are other necessary processes — such as candour or safeguarding — being handled separately where required?

References & Further Resources

PSIRF is an NHS England framework and this guide therefore focuses on healthcare in England. The national framework is supported by several detailed documents and learning-response tools.

NHS England - PSIRF	The main national page explaining the framework, its four aims, scope and supporting guidance.
Patient safety incident response standards	Version 1.3, updated January 2026. Sets the minimum expectations for policy, planning, oversight, competence, involvement and proportionate responses.
Engaging and involving people	NHS England guidance on compassionate engagement with patients, families and staff following a patient safety incident and involving them in learning responses.
Learning response toolkit	National system-based tools and guides for learning from patient safety incidents, including different response methods and the SEIPS systems framework.
Guide to proportionate responses	Guidance supporting organisations to choose and plan responses that are appropriate to the incident, risks and learning opportunities.
NHS Patient Safety Strategy update 2026	Current NHS England progress update confirming PSIRF implementation across secondary care and describing ongoing primary-care pilots.

How to use these resources

Use the main PSIRF framework together with the current response standards and supporting guidance. For an individual incident, the healthcare provider's own patient safety incident response policy and plan can help explain its local approach, priorities and routes for involvement.