NHS
Blood and Transplant

Board Meeting in Public
Tuesday, 22 July 2025

Title of Paper	Patient Safety Incident Response Framework (PSIRF) – Phase 1 Evaluation and 2025/26 Transition Plan	**Agenda No.**	3.5
Nature of Paper	☒ Official	☐ Official Sensitive	
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Presenter(s) at Meeting	Dee Thiruchelvam, Chief Nursing Officer		
Presented for	☐ Approval ☒ Assurance	☐ Information ☐ Update	

Executive Summary

The report provides a summary of activities and achievements for the implementation of the Patient Safety Incident Response Framework (PSIRF) at NHSBT since June 2024.

PSIRF phase 1 implementation has been reviewed against the agreed deliverables and the update on progress report brought to the Clinical Governance Committee (CGC). In May 2025, stakeholder feedback was provided via multiple sources. This provided rich data on the experience of the process of PSIRF thus far at NHSBT, in addition to a mapping of the implementation against the actions.

The feedback from stakeholders and mapping of achievements against the previous plan has informed the next stage of the transition plan, which is included in the report. Process refinements are being recorded in the current documents, Management Process Descriptions (MDPs), and Policies.

Governance of implementation has been refined. The PSIRF Delivery Group and Board have formally been decommissioned following the proposal at CQSGG and a monthly PSIRF implementation steering group will form operational oversight, with governance in CQSGG and CGC respectively. Stakeholders from the previous two groups will be invited to the new group.

Finally, it is noted that the Value Stream Analysis (VSA) Quality workstream will support further integration/implementation of PSIRF and this is due in January 2026. Stakeholders in Quality and operational directorates have been integral to the PSIRF transition plan.

Previously Considered by	
Clinical Quality and Safety Governance Group (CQSGG) June 2025 Clinical Governance Committee (CGC) July 2025	
Recommendation	The Board are requested to receive the report, acknowledge the key achievements of stakeholders so far and receive the 2025/26 PSIRF transition plan for assurance.
Risk(s) identified (Link to Board Assurance Framework Risks)	
P-01 Patient and Donor Safety	
Strategic Objective(s) this paper relates to: [Click on all that apply]	
☒ Collaborate with partners ☒ Invest in people and culture ☐ Drive innovation ☐ Modernise our operations ☐ Grow and diversify our donor base	
Appendices:	

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Patient Safety Incident Response Framework (PSIRF)
Phase 1 evalutaion and 2025/26 transition plan

National Context

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

The framework represented a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS. It is a key part of the NHS patient safety strategy.

PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents
- Supportive oversight focused on strengthening response system functioning and improvement

Evaluation of PSIRF Phase One

Since the launch of PSIRF regular updates have been provided to the Clinical Governance Committee (CGC) and the Board.

In May 2025, NHSBT completed an evaluation of the first phase of PSIRF implementation. Table one shows the deliverables against key performance indicators and there is much to recognise and celebrate.

One area of improvement is where the investigation and closure timeline has exceeded the 60 days for PSIIs and have all been elongated. There are multiple reasons for this, and this will be a key part of the refinements to support and resolve, providing a supportive and clearer process, accountability and governance structure together with a monitored timeline in the onward transition and embedment.

Table 1. Measures/ Targets, May 2025

PSIRF Evaluation	Measure/Target	May-25
Number of PSII commenced or declared (Total)	Number declared in line with safety priorities	8
Local Priority		8
National Priority		0
PSII led by trained Learning Response Lead	100%	100%
Trained engagement lead identified to support those affected by the incident (PSII)	100%	N/A*
Patients, donors and families offered the opportunity to participate in the learning response (PSII)	100%	100%

PSIRF Evaluation	Measure/Target	May-25
Investigations completed within 60 working days (PSII)	Number overdue	6 (75%)
Response lead not involved in the incident/line manages those involved in the incident (PSII)	100%	100%
Trained oversight lead involved in investigation sign off	100%	100%
Two Patient and Donor Safety Partners	Number/2	2

A key part of the PSIRF program is to ensure colleagues are well versed in the NHS Patient Safety Syllabus[1] and training was made available. Table two shows the training attendance and is mapped against the number of places provided and then number of attendees. Training has been met to a high level in most of the areas and an ongoing training needs analysis is required as staff change within the organization.

Table 2 Training attendance for the PSIRF modules

Training attendance	Number of places	Number attended
Systems approach to Patient Safety Incident Investigations	80	64
Patient, family & staff involvement in learning from patient safety incidents	80	61
Oversight	40	19
Creating a Just & Learning Culture	260	247
After Action Reviews	180	163

During May 2025, to compliment the KPIs, qualitative feedback was gathered. This was provided via several methods; stakeholder engagement sessions; an online form; individual meetings; feedback through the weekly patient, donor safety incident review group (PDSIRG) and wider stakeholders.

The key feedback was thematically reviewed, not to detract from individual views, with the following being deemed as key themes and broadly categorised in the headings stated below. There was good practice and positive statements too. The themes included -

a) Collaboration/Integration
b) Organisational Culture
c) Reporting templates
d) Working environment
e) Training
f) Processes
g) Governance

[1] NHS Patient Safety Syllabus training - elearning for healthcare

h) Language
i) Communication.
j) System clarity
k) Operational vulnerability
l) Efficiency

The detail in the feedback provided suggest the current policy and process require review to address the feedback and shape onward transition. This is currently in progress and a draft will be circulated to the stakeholders for consideration.

Table three shows the updated PSIRF transition plan which will be operationally delivered via the PDSIRG and assured at CGC.

Table 3. PSIRF 2025/26 transition plan.

#	Action	Lead	Timeline
1	Refine and confirm governance structure for PSIRF	Refine and add to Policy and Plan CH/EB/JW/IA/MW	June 2025
2	Provide update briefings to the organisation on patient safety	Paper to CQSGG/CGC. SMT/SLT EB/IA	Meeting dates June/July
3	Review current e-learning for patient safety and training and education needs of stakeholders	CH/EB/MW/IA	July 2025
4	Convene PSIRF delivery group to review process	PDSIRG to add to agenda once a month	July 2025
5	Develop improvement framework aligned with quality.	VSA MW/IA	December 2025/Jan26
6	Develop a shared learning framework proposal	CH/EB	August 2025
7	Review PSII and PSIRF MPDs and related documents. Add improvements and clarifications (following learning of the process from PSIIs undertaken). Redesign reporting process (to improve ease of use)	CH/JW/EB	June 23 2025
8	Identify the need for the different levels of investigator training and an allocation system. Develop the skills and capacity to undertake more systems-based investigations proportionate to need	PSII Inv. Allocation Align with VSA consider AAR /inv levels learning skills EB /IA	June 2025 Dec-Jan 2026
9	Disseminate training produced by national patient safety team	CH	June 2025
10	Contribute to VSA.	All	Dec 2025
11	Establish links with NHSE ICB to support local oversight particularly for shared PSII	CH/ EB	Dec 2025

Summary

This paper includes a summary of the PSIRF process to date. Much has been achieved, and this should be recognised for the organisation as a whole and all individuals involved in the process to date.

The key parts of the next phase of transition are process, governance clarity, and further integration with the wider incident processes to create efficiency and clarity for teams acknowledging the VSA in progress. Addressing this will largely be done by refining the current associated MDP's/policies/plans and governance which is in progress. This will go to stakeholders for final comment before implementing in July 2025.

Following this, the PDSIRG meetings will, once a month, have an additional agenda item to enable a platform for feedback and a process for further refinement. The previous PSIRF Delivery Group and PSIRF Board were proposed and approved to be decommissioned having successfully supported PSIRF to this stage. Future updates will be provided through the governance and leadership structure.

The action plan shows the next stage of transition together with current in-progress work from previous review. Following completion of this, the next milestone will be supporting the outcomes of the VSA - the ambition of which is to have an integrated incident process whilst ensuring the fundamental approach of PSIRF's continuous learning culture is embedded.

Recommendation

The Board are requested to receive this report, acknowledging the key achievements of stakeholders so far and to receive the plan for the next stage of transition for PSIRF for assurance.