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Patient Safety Incident Response Framework (PSIRF) and Utilisation of MOMENTS to Facilitate Conversations

Gill Travers, Registered Midwife, Audit & Assurance Manager – Specialist Services

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Patient Safety Incident Response Framework

(PSIRF)

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The initial PSIRF framework was published in 2022, with pilot sites across England testing a new approach to learning from patient safety incidents.

In April 2024 PSIRF was launched across all standard NHS contract services and is in the process of being piloted in primary care.

- Replaces the Serious Incident Framework and removes the 'serious incident' classification and threshold for it
- Embeds patient safety incident response within a wider system of improvement.
- Prompts a significant cultural shift towards systematic patient safety management.
- It does not mandate investigation as the only method for learning from patient safety incidents, or prescribe what to investigate.

- The patient safety incident response framework was launched in 2024 following a 2 year pilot period in organisations across England.

- It is a significant shift from the previous serious incident framework as this focused on the perceived level of harm to a patient/staff member.

- PSIRF moves us to a focus of identifying significant learning where we can implement system or organisational improvement work to help to reduce the chance of an incident happening again and to develop safer ways of working.

- PSIRF focuses on work as imagined versus work as performed, exploring both the facilitators and the barriers to being able to achieve the safest care provision for our patients and families.

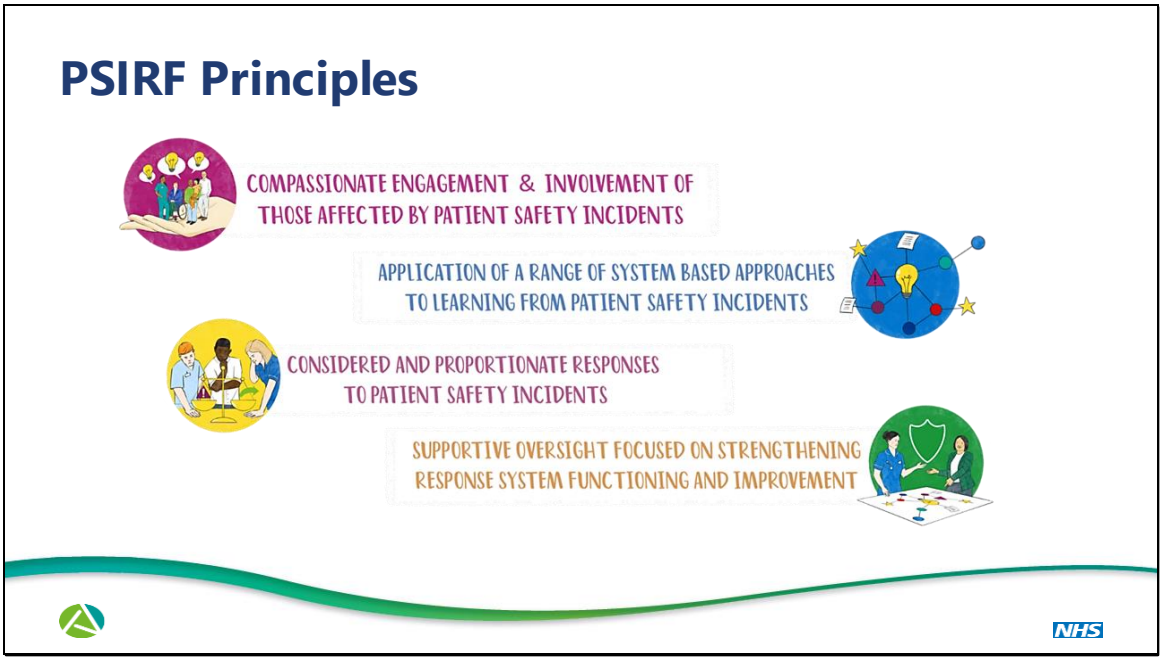
- PSIRF does not look to assign any individual blame.
- In May 2025 the Just Culture guide was superseded by the Being Fair tool was launched by NHS England » Being fair tool: Supporting staff following a patient safety incident – this tool has been designed to support decision-making for patient safety incidents which may be related to workforce practices and to ensure that you

- as staff are not treated unfairly following a patient safety incident.

- It is acknowledged that patient safety incidents are usually signs of underlying systemic issues that require wider system-level action. Action singling out an individual is rarely appropriate.

- By treating staff fairly, the NHS can foster a culture of openness, equity and learning where staff feel confident to speak up when things go wrong. Supporting staff to be open about mistakes allows valuable lessons to be learnt and prevents errors from being repeated.

- In rare circumstances a learning response may raise concerns about an individual's conduct or fitness to practise. It is in these specific circumstances that the being fair decision-making tool can help.
- There are 5 questions which must be explored prior to remedial action for individuals is considered.



Compassionate engagement includes staff as well as patients, service users, carers or family members of those affected by the incident – as it's important to understand that context, and experience, of those directly involved.

There are a range of system based approaches within the PSIRF toolkit for use, supporting providers to perform a considered and proportionate response to an incident.

Oversight is now focused on improving strengthening response system functioning – including facilitating responses across system providers – and development of quality improvement to ensure that the actions developed support long-term change and are not just a tick-box exercise, as was the reported experience of some who previously performed oversight roles in the serious incident framework.

With the on-going changes in commissioner responsibilities and move from NHS England into the Department for Health and Social Care, it has not yet been determined where the duties of system oversight will sit – however, there has been on-going development work through the Health Innovation Network to ensure that the oversight model reflects the needs of both commissioners and providers, and is

replicable across care settings.

PSIRF Learning Responses

1. SWARM Huddle
2. MDT / Round table review
3. After Action Review
4. Patient Safety Incident Investigation (PSII)

There are 4 key learning responses to patient safety events under the PSIRF.

- **SWARM Huddle** – can be used after any event where patient safety was at risk – whether this was an incident where harm occurred or a near miss.
- It takes no more than 30mins
- Normally chaired by a senior lead who then generates a brief report
- It involves people directly involved in the incident or near miss.
- SWARMS enable us to identify immediate learning with early identification of actions; research suggests that a SWARM may help teams to connect after an event to reduce social isolation and increasing stress from frequent rumination over the incident.

- **MDT/round table review** – more in depth with input from different disciplines to identify learning from multiple safety incidents which may explore a safety theme, pathway or process to understand work as done.
- No defined time allocation but for a thorough discussion it would be anticipated that this may need 2-3hours engagement in an interactive workshop.
- Likely to be led by a Trust patient safety facilitator using the NHSE MDT template.
- These usually involve people directly involved in these events from the MDT, plus

- patient safety experts and other senior clinicians.

- **After Action Review** – can be used after any event where patient care or service was not as effective or safe as expected, or to explore better than expected results to determine how the practice might be amplified and shared more widely.
- AARs take approximately 45-90mins depending on the complexity of the event and the number of people involved.
- Involves those directly involved in the event and others connected to them or the patient pathway, patients and families may be involved or their views may be sought and presented by a patient advocate to support staff psychological safety during discussion.
- This will be facilitated by a trained 'conductor' – this could be someone from within the MDT or external to support impartiality.
- The focus during this discussion is on learning.

- **Patient Safety Incident Investigation (PSII)** – this is an in-depth review – this may either be for a single incident if there is significant learning, or it may be a thematic analysis of a cluster of events which, individually, may not have significant learning, but due to the clustering it is believed there will be substantial learning to be achieved.
- This is most often used when there has been significant harm or it is believed that there is substantial learning to be achieved.
- PSIIs may take anywhere from 20-80hours over the course of several weeks
- These are performed by trained patient safety investigators who collate the data, analyse the findings and writes a report with safety action recommendations.
- Patients and families will be engaged in this review to ensure that thier concerns and views are represented.

MOMENTS

MOMENTS is a framework designed to:

- **spark discussion** and deliberation, to encourage reflection and curiosity;
- **encourage the provision of protected time and space**, to enable mutual understandings and consensus for action to be reached;
- **help staff to shape the development** of their service/unit's local safety culture;
- **provide support** to ongoing initiatives to improve local safety cultures.

It is likely individuals will have different perspectives on the same phenomenon, and this is to be encouraged.

The everyday, little things we do make a difference to the care we provide to our service users and experiences of staff working in the NHS.

Understanding what and how we do these things is crucial to building positive safety cultures.

Safety culture is the relationships, practices and values of **EVERYONE** in the NHS, performed **EVERY DAY** to provide **COMPASSIONATE CARE** for all.

But, finding the time to work out what we are doing well in our teams and making 'safety culture' tangible can seem overwhelming.

Moments is a framework to explore local safety cultures through everyday practices.

Utilisation of the framework in PSIRF responses, particularly after action reviews and MDT or round tables, can help teams to objectively review work practices and the systems, processes and, in some cases, the accepted workarounds that are in use.

The framework encourages conversations to take places over 45mins to an hour, however, it is possible to use the framework elements in a shorter time period to identify key elements or challenges which may have contributed to a patient safety event, for example when discussing an incident during a SWARM huddle.

How was MOMENTS developed?

- MOMENTS was informed by the experiences of staff in ten maternity and neonatal services across England who participated in a research project about good safety culture, alongside contemporary social theory.
- The project explored what contributes to a good safety culture via positive enquiry, identifying strengths rather than focussing on mistakes, accidents or incidents.
- When developing plans to nurture safety culture, the process of engagement is as important as the plans themselves.
- Giving all team members the opportunity to be heard, and to come together to collectively create positive change will encourage innovation, buy-in and implementation of any future change.

This approach can be used in any health and care team.

A recorded webinar which explores the research behind and development of the MOMENTS tool is available here: https://youtu.be/z7e67Vxxai0 or access by scanning the QR code.

Safety culture is challenging to 'surface', but we know it is important.

Often, we try to 'surface' or view our culture when things have gone wrong, and as a result we try and design our improvementactions in response to this – which can lead to them feeling like tick-box exercises as they often centre around the implementation of checklists or human factor analysis. These are often linked to an identified missing individual behaviour or system.

There has been a tendency in research to overlook the 'everyday' – what our team/department/organisational culture looks like on an average day,

It was noted by the research team that all 10 organisations with positive safety culture shared similar values, including:

- **Transparency, openness and authenticity**
- **Respect and compassion**
- Passion and commitment
- Staff empowerment
- **Attentiveness to staff wellbeing**
- Mutuality, trust and dialogue
- **Civility**
- Collegiality and inclusivity
- Unity, coherence and consistency

Social Practices & Values Introduction

Making tea for someone is an example of a social practice.

Practices are made up of **materials** (things that we need to deliver the practice), **meanings** (enacted through the practice) and **competencies** (staff knowledge and skills required to accomplish the practice).

The aim of MOMENTS/this session is to spark discussion and deliberation, to encourage reflection and curiosity and to enable staff to shape the development of their service/unit's local safety culture.

In front of you, you have worksheet 1 - Everyday Social Practices: unpacking the elements of social practices

We need Materials – these are the things that we need to make a cup of tea: Tea bags / tea / hot water / drinking vessel

We need competencies - the knowledge and skills of how to make a cup of tea What type of tea is needed? How long to leave the tea-bag in for? Do I need to warm the pot? How much milk? Can I safely boil water?

And there are Meanings associated with making a cup of tea It can be an act of care / it can signal an informal chat-assurance / can be a conversation opener / can act as a social leveller

Our values can be supported/displayed when we undertake the practice of making somebody a cup of tea at work – what are some of the values that you personally associate with this social practice?
Examples:
- Respect and compassion,
- Transparency, openness & authenticity
- Attentiveness to staff well-being
- Mutuality, trust and dialogue

If we don't get it right, then it can actively work against our values. For example:

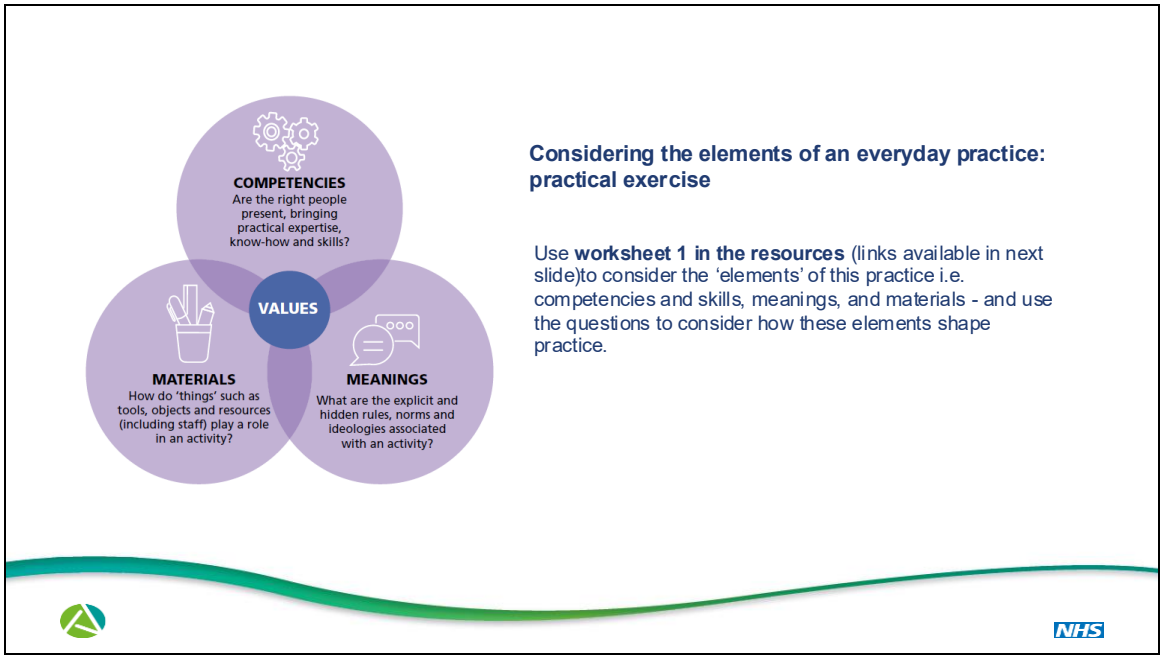
- If we don't have the necessary materials - no teabags [organisation stops providing them]
- If the tea-maker produces a poor cup of tea [lacks the competencies / know how]
- If we don't share a cultural understanding of what making a cup of tea for somebody means

Then the practice can become detached from its values and so we can examine the materials, meaning and competencies and see where improvements can be made.

We can also identify what is working well and where the strengths are, as well as common work-arounds in use – consider, what have you used in place of a teaspoon when making tea previously? Previous participants have described using knives,

forks, straws, their fingers to fish out the point of the teabag circling like a shark fin! The wooden sticks that are often provided in cafes, and, in some cases their pen – which is obviously not recommended due to infection control, but was thought, at the time, to be an appropriate work around due to lack of available tools.

If improvement can't be made, then is there another way in which we can demonstrate the values embodied in tea-making?



During the pilot it was found most beneficial to provide these worksheets as paper copies as teams often wanted to take the worksheets away with them to support continuation of the conversations and to help capture their thought processes when devebping improvement actions.

15minutes – timings are provided on the table facilitator resource pack for each exercise.

Use the worksheet. Ask the group to look at their chosen practice to help guide them through this.

Use the questions on the sheet to prompt the team to discuss each of competencies, meaning and materials in turn.

Ask questions to steer the group to think broadly about what or who is required for each of the competencies, meanings and materials. Often items from one will come up as you are talking about another and values may start being discussed. Get the team to make a note of these on the worksheet.

MOMENTS Resources

The Facilitator Guide, handouts and worksheets are designed to support healthcare teams to take next steps with their clinical teams, in response to their local Safety Culture survey report.

They consist of a series of exercises that teams can use to work with their teams to better understand their own local safety cultures.

This resource is designed to help leaders and teams understand both what is happening in their service around safety, but more importantly why this is happening and what it means for the implementation of more formal safety work.

Links:
https://moments-safety.com/s/FacilitatorGuideFINAL2.pdf

https://moments-safety.com/s/ExerciseHandout3.pdf

https://moments-safety.com/s/ExerciseWorksheet2.pdf

Acknowledgements

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Content was adapted and/or developed from the following sources:

- NHSE PSIRF Toolkit
- MOMENTS & Improvement interventions repository slide deck shared by the NHSE Perinatal Culture and Leadership Team, Maternity and Neonatal Programme.
- Graphics and content from the https://moments-safety.com/ with consent from University of Leicester

Culture Resources

"Organisational culture is everyone's business. Everyone within healthcare has an important role to play, across all professional groups and at all levels."

- NHS Resolution – Being fair 2
- We are not getting safer: Patient safety and the NHS staff survey results – 26 March 2024
- NHS Staff Survey – National Results
- NHS England – A Just Culture Guide
- NHS England - Safe Learning and Environment Charter
- NHS England - 15 Steps Challenge
- NHS Scotland - Safety culture discussion cards
- UK Parliamentary Inquiry - NHS leadership, performance and patient safety - Oral evidence April 2024
- NHS England - Changing healthcare cultures through collective leadership
- Improvement academy – just culture network
- Improvement academy – just culture assessment framework
- Sidney Dekker - Restorative Just Culture Checklist
- Case study: Favourable Event Reporting Forms (FERF)
- Surviving Healthcare Report: Surviving in Scrubs (2023)
- MNSI Factors affecting the delivery of safe care in midwifery units (May 2024) – national learning report
- Turner *et al.*, (2022) Restorative just culture significantly improves stakeholder inclusion, second victim experiences and quality of recommendations in incident responses – access here