

PSIRF-SELECT: A Structured Qualitative Deliberation and Documentation Framework for Selecting Proportionate Learning Responses under the Patient Safety Incident Response Framework in England

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How to cite this paper: Bataweel, A.O. (2026) PSIRF-SELECT: A Structured Qualitative Deliberation and Documentation Framework for Selecting Proportionate Learning Responses under the Patient Safety Incident Response Framework in England. *Health*, 18, 941-976.
<https://doi.org/10.4236/health.2026.1810059>

Received: August 22, 2026
Accepted: October 20, 2026
Published: October 23, 2026

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Abstract

Background: In England's National Health Service (NHS), the Patient Safety Incident Response Framework (PSIRF) replaced prescriptive serious-incident thresholds with locally planned, considered and proportionate responses focused on learning and improvement. National guidance identifies important considerations, while local NHS organisations have developed decision meetings, flowcharts and matrices. However, implementation evidence and a 2025 report from the Health Services Safety Investigations Body indicate continuing uncertainty and variation in the practical selection of learning responses. **Aim:** To propose PSIRF-SELECT, a structured qualitative deliberation and documentation aid for use at the point where an NHS provider decides whether, why and how to undertake a learning response. **Development:** A targeted search and narrative synthesis of publicly accessible official guidance, peer-reviewed literature, international frameworks and local NHS tools was undertaken on 14 August 2026 and updated on 22 August 2026. The purpose was to identify existing decision support, examine whether the proposed operational gap was credible and derive candidate domains for the framework. This was not a systematic, scoping or rapid review. Candidate domains were compared with national requirements and relevant literature on systems thinking, involvement, outcome bias and investigation quality. **Framework:** SELECT comprises six domains: Specified requirements and immediate safety; Existing knowledge, evidence and improvement activity; Learning questions and potential; Engagement and equity; Context, complexity, capacity and coordination; and Type, transparent rationale and triggers for reconsideration. The

word SELECT naturally contains two E positions: the first E concerns existing knowledge and improvement, while the second E concerns engagement and equity. The full domain names are used throughout to prevent ambiguity. Each domain is answered in words, not points. The output is a human-approved response with documented alternatives, uncertainties, engagement commitments and review triggers; no score or automatic recommendation is generated. **Illustration and Evaluation:** Three wholly synthetic cases demonstrate different outcomes: a patient safety incident investigation, a thematic review and no additional individual learning response beyond recording, engagement and monitored improvement. Co-design, feasibility testing and prospective multi-site validation are required before claims of effectiveness or routine adoption. **Conclusion:** PSIRF-SELECT offers a testable way to operationalise and make visible the reasoning already expected by PSIRF. Its contribution is integration, transparency and evaluability rather than replacement of existing guidance or judgement.

Keywords

Patient Safety, Patient Safety Incident Response Framework, PSIRF, National Health Service, NHS, England, Incident Response, Learning Response, Systems Thinking, Decision Support, Patient Involvement, Quality Improvement

1. Introduction

Patient safety incident response has two distinct challenges: deciding what form of learning response is proportionate, and then conducting that response well. PSIRF addresses both by replacing the previous Serious Incident Framework with a system that prioritises compassionate engagement, system-based learning, considered and proportionate responses, and supportive oversight [1]-[4]. The change is intentionally important: severity of outcome alone is an unreliable proxy for learning value, while exhaustive investigation of every event can consume capacity without generating additional knowledge or improvement.

Flexibility, however, transfers responsibility to local decision-makers. They must interpret national requirements, their patient safety incident response plan (PSIRP), current intelligence, the needs of people affected, existing improvement work, the learning question, available expertise and cross-system dependencies. They must also explain why one response was chosen and another was not. A defensible decision therefore requires more than a flowchart endpoint; it requires a visible reasoning process.

This paper proposes PSIRF-SELECT as a structured deliberation and documentation aid. It is deliberately positioned inside PSIRF rather than as an alternative to it. SELECT is intended to help a multidisciplinary group organise and record the considerations already distributed across national guidance, local tools and patient-safety evidence. It is not a diagnostic test, risk score or algorithm. It does

not decide whether an incident is blameworthy, does not direct employment or professional-regulatory action and does not merge external statutory processes with local learning.

1.1. Aim and Research Question

The paper asks: Can a concise six-domain framework make the selection of a proportionate PSIRF learning response more transparent, consistent and evaluable without recreating rigid thresholds or displacing professional judgement?

The immediate aim is conceptual: define the framework, show where it fits, test it against synthetic cases and specify a responsible evaluation programme. Claims about reliability, validity, usability, efficiency, equity or safety impact are reserved for later empirical work.

1.2. Claimed Contribution

In the public sources reviewed, the author did not identify an openly available, nationally standardised and empirically validated point-of-decision instrument that integrates the key considerations and records the rationale for choosing among PSIRF learning responses. This statement is deliberately narrower than claiming that no decision tool exists.

Local NHS flowcharts, decision meetings and FutureNHS resources already exist and are important counterevidence to any “first tool” claim [5]–[10]. SELECT therefore claims potential value in integration and documentation: it makes engagement and equity explicit, defines the learning question, records alternatives and uncertainty, separates parallel routes, and creates a minimum dataset that can be audited and validated.

2. The English PSIRF Context and the Selection Problem

2.1. What PSIRF Requires

PSIRF is the NHS approach to developing and maintaining effective systems and processes for responding to patient safety incidents for learning and improvement [1]. It applies contractually to services delivered under the NHS Standard Contract, with additional guidance for application outside NHS Trusts and in primary care contexts [1] [11]. Providers are expected to maintain a patient safety incident response policy and a PSIRP based on their incident profile, stakeholder engagement and improvement priorities [2] [3].

The guide to proportionate response establishes a sequence rather than a severity threshold [2]. Nationally specified responses and applicable external requirements are considered first. Locally, the organisation considers its PSIRP, the circumstances and needs of those affected, what is already known, current improvement activity and whether a response is likely to generate new learning. It may select a patient safety incident investigation (PSII), after action review (AAR), multidisciplinary team (MDT) review, swarm huddle, thematic review or another suitable system-based approach [2] [4]. When a risk is understood and effective

improvement is active and monitored, an additional individual learning response may not be proportionate—provided the event is still recorded and those affected are engaged appropriately [2].

2.2. Why Selection Remains Difficult

The selection task is a form of structured judgement under uncertainty. Information may be incomplete; harm outcome can bias perceptions of culpability; the most visible event may not represent the most important system risk; patient and family questions may differ from the organisation's initial learning question; and cross-organisational dependencies may be outside the decision panel's authority. Resource constraints matter but must not be disguised as a lack of learning potential.

HSSIB's 2025 examination of investigation under PSIRF reported uncertainty and variation in practical application and specifically invited NHS England to provide practical steps for selecting the most appropriate learning response so organisations can adopt a robust, standard approach [12]. This is direct evidence of an operational need, but it is not evidence that no tools exist or that a new framework will be effective.

The NIHR-funded RESPONSE study provides additional evidence that implementation and impact of the changing English incident-response system remain active research questions [13].

Empirical literature strengthens the rationale for transparent deliberation. A rapid review of the English NHS before PSIRF found investigation, learning and relational challenges [14]. Studies of systems-based practice and investigation reports show continuing difficulty moving from linear explanations to systems thinking [15]-[18]. Experimental evidence demonstrates outcome bias in judgements of culpability and punitive recommendations [19]. Policy and qualitative research show variability in involvement and the potential for post-incident processes to compound harm [20]-[22]. Together, these findings support explicit prompts, diverse participation and a recorded reasoning chain; they do not validate a particular selector.

International guidance and established patient-safety literature also support systems-oriented learning, caution against simplistic root-cause explanations and emphasise the relationship between analysis and improvement [23]-[28].

2.3. Existing Provision and the Residual Gap

The national guide and standards supply the substantive considerations [2] [3], while the learning-response toolkit supplies methods [4]. Public local documents show that NHS organisations have operationalised selection through flowcharts, rapid review and decision meetings. Examples include Great Western Hospitals, University Hospitals Dorset, Kent and Medway, York and Scarborough, and South West Yorkshire Partnership [5]-[9]. A FutureNHS decision-making flowchart has also been referenced in BMJ International Forum material [10].

Table 1 distinguishes the support already available from the narrower residual question that PSIRF-SELECT is intended to address. It shows why the proposal should be framed as an integrated minimum reasoning record, not as the first decision tool.

Table 1. Existing PSIRF decision support and the residual operational question.

What is available	What it contributes	Residual question for SELECT
National PSIRF guidance and standards	Principles, minimum expectations, relevant considerations and response options.	Can those distributed considerations be captured in one consistent, auditable point-of-decision record?
Learning-response toolkit	Methods for conducting and reviewing system-based learning responses.	How is the method selected before it is commissioned?
Local flowcharts and decision meetings	Practical routes adapted to local governance and PSIRPs.	Can a shared minimum reasoning dataset improve transparency without preventing local adaptation?
Research on investigation quality and engagement	Evidence on systems thinking, bias, involvement and quality limitations.	Can design safeguards be embedded at selection, before resources and expectations are fixed?

Note: PSIRF, Patient Safety Incident Response Framework; PSIRP, Patient Safety Incident Response Plan.

The residual gap is therefore not the absence of any decision support. It is the lack identified in the reviewed public literature of a common, validated, minimum deliberation-and-documentation structure that integrates the full set of considerations and makes the decision reviewable. SELECT is one hypothesis for filling that gap.

3. Conceptual Development Method

3.1. Targeted Literature and Policy Review

To inform framework development, a targeted search and narrative synthesis of peer-reviewed literature, official national guidance and publicly available local PSIRF tools was undertaken on 14 August 2026 and updated on 22 August 2026. The purpose was to identify existing decision-support approaches, examine whether the proposed operational gap was credible and derive candidate domains for SELECT. Sources included NHS England and HSSIB webpages and documents; PubMed and publisher pages using exact and broader combinations of PSIRF, incident investigation, learning response, systems thinking, selection, proportionate response, engagement and outcome bias; public NHS Trust websites; and international incident-analysis resources. Exact-name searching for “PSIRF-SELECT” was also conducted. Citation details and source-by-source implications are provided in **Supplementary Table S1**, which maps each source to the SELECT domain(s) or design principle(s) it informed.

Sources were included when they: 1) defined a national requirement or organisational role; 2) provided direct evidence about PSIRF implementation or learning-response selection; 3) offered empirical or conceptual evidence relevant to

system analysis, involvement, bias, proportionality or investigation quality; or 4) demonstrated an existing local selection tool. No date restriction was imposed for foundational systems literature. Official and primary sources were preferred.

This targeted review was designed to inform the development of PSIRF-SELECT and was not intended to constitute a systematic or scoping review of the complete evidence base. A future formal evidence review could extend this work through a reproducible database search, broader database coverage, citation tracking and independent screening.

3.2. Framework Synthesis

Candidate decision elements were first extracted from national PSIRF requirements. They were then grouped by the practical question a decision panel must answer. The groupings were tested against four safeguards from the literature: system orientation, engagement of those affected, resistance to outcome-driven and individual-blame bias, and transparent reasoning. Finally, the domains were compared with publicly available local tools to remove any claim of being the first flowchart and to identify the proposed added elements.

The resulting mnemonic was refined to preserve six distinct functions without turning them into a numerical score. Because SELECT contains two E positions, the first is always written as “E—Existing knowledge, evidence and improvement activity” and the second as “E—Engagement and equity”. Engagement and equity are informed by national inequalities guidance [29]. The “C” domain explicitly includes capacity and coordination so lack of expertise or cross-system authority is visible rather than silently determining the outcome. The “T” domain requires the response type, rationale, alternatives, uncertainty and reconsideration triggers.

OpenAI ChatGPT (web application; accessed August-September 2026) was used during manuscript preparation as an assistive tool for evidence organisation, drafting support, language editing and document formatting. The author reviewed the resulting source selection, interpretations and framework content, made the final decisions and accepts responsibility for the manuscript.

3.3. Design Principles

- Fidelity: every domain should be traceable to PSIRF guidance or relevant patient-safety evidence.
- Human authority: the framework structures discussion; an authorised multi-disciplinary group owns the decision.
- No arithmetic: domains are not weighted or totalled, and there is no cut-off for a PSII.
- Proportional information: gather enough information to choose a response, not a hidden investigation before the investigation.
- Visible uncertainty: a preliminary assessment and later reconsideration are legitimate outcomes.
- Engagement before closure: questions and needs of those affected are inputs

to selection, not an optional activity after the decision.

- Separation of purposes: PSIRF learning is coordinated with, but not merged into, regulatory, employment, professional, coronial, complaints, claims or criminal processes.
- Evaluability: the minimum decision record should enable audit of consistency, process quality, equity and outcomes.

4. The Proposed PSIRF-SELECT Framework

4.1. Intended Users, Timing and Unit of Decision

The intended users are provider patient-safety teams, clinical/service representatives, improvement specialists, engagement leads and Patient Safety Partners or other patient representatives within the organisation's authorised response-selection governance. ICB or partner-organisation participation is added when the system boundary crosses organisations. The decision unit may be a single event, a cluster, a safety issue identified from broader intelligence or an emerging risk—not necessarily an incident with severe harm.

Minimum functional composition. SELECT does not prescribe fixed job titles, a universal quorum or a majority-voting rule. The record must, however, show proportionate coverage of five functions: 1) an authorised patient-safety/PSIRF decision lead; 2) a relevant clinical or operational perspective; 3) learning-response or systems/human-factors expertise; 4) improvement expertise able to assess current controls and measurement; and 5) an engagement and patient/public perspective. One person may cover more than one function where competence and conflicts are addressed. Direct patient or family input is distinct from general patient/public representation.

Unavailable or triggered perspectives. A patient/public, cross-organisational or independent perspective may be obtained through a trained alternate, documented asynchronous input or a specifically invited contributor. Cross-organisational and independent input are required when the decision boundary or conflict assessment triggers them, rather than as standing membership for every decision. If a material perspective cannot be obtained without unsafe or disproportionate delay, the initial decision is recorded as provisional with the reason, responsible contact/escalation owner and a defined reconsideration trigger.

Approval rule. Final approval remains with the accountable person or group authorised by the provider's published local governance. Approval requires confirmation that Gate 0 and all six domains have been considered; relevant perspectives, conflicts and capacity constraints are recorded; plausible local alternatives have been compared where choice remains; and an owner, communication commitment, review date and triggers are specified. Consensus should be sought. Where it is not achieved, the accountable approver records the dissent and the reason for the final decision. SELECT does not override the provider's scheme of delegation.

SELECT begins after immediate clinical care, urgent risk control and initial re-

cording have started. It is used before a learning response is commissioned, or when new information requires an earlier decision to be reconsidered. It can be applied in a meeting or asynchronously, but the final record should identify who participated and who approved the decision.

4.2. Gate 0: Actions That Must Not Wait

Gate 0 is not optional. Before deliberating about learning method, protect patients, meet immediate clinical needs, preserve relevant information, record the event, begin compassionate communication, consider Duty of Candour and identify any nationally specified or external notification/investigation route. SELECT cannot be used to delay or avoid these actions.

A nationally specified response determines the required component and is recorded with its owner; it is not treated as one discretionary option among local methods. The panel then considers whether that response alone addresses the provider's distinct local learning questions or whether complementary local learning, coordination or improvement activity is also necessary. Any additional local response must add a defined purpose and avoid duplicating the nationally specified work. Other external routes may influence timing, information sharing, independence or scope, but they do not remove the need to record residual local actions. Where facts are insufficient to complete the gate safely, the correct decision is a time-limited preliminary assessment with named questions and a review date.

4.3. The Six Domains

Reading order is important: S, E (Existing), L, E (Engagement), C and T. The two E domains are different. They are distinguished by their full names rather than by numbered labels, because numbers could be mistaken for scores or levels.

Table 2 defines each domain, the core question it asks and the minimum information expected in a SELECT record. Together, the domains combine non-negotiable requirements, existing evidence, learning potential, engagement and equity, operational context and the final rationale.

Table 2. PSIRF-SELECT domains, core questions and minimum content.

Domain	Core question	Minimum content
S Specified requirements and immediate safety	What must happen regardless of local preference?	Immediate care and risk controls; nationally specified responses; local PSIRP priorities; Duty of Candour; safeguarding; CQC or other notifications; MNSI, MHRA, coroner or police considerations; preservation of evidence; conflicts requiring independence.
E Existing knowledge, evidence and improvement activity	What is already known, and is improvement actually working?	Known mechanism and contributory factors; previous local/national learning; current controls; improvement owner; measures, trajectory and reliability; whether this event adds a new mechanism, population, setting or failure of the existing control.

Continued

L Learning questions and potential	What unanswered question matters, and can a response answer it?	A specific learning question; decision audience; potential to generate actionable system knowledge; whether a single event, rapid team review, thematic analysis or comprehensive investigation best matches the question.
E Engagement and equity	Whose questions and needs must shape the response?	Patient, family and staff questions; preferred involvement; communication and support; accessibility and reasonable adjustments; cultural and language needs; possible differential impact, under-recognition or unequal access to learning and improvement.
C Context, complexity, capacity and coordination	What system boundary and capability are required?	Pathway and organisational boundaries; interfaces and dependencies; work-as-done; required expertise; independence; conflicts; time and capacity; ICB or partner coordination; data availability; feasibility. Capacity constraints must be documented as constraints, not relabelled as low learning potential.
T Type, transparent rationale and triggers for reconsideration	Which response is proportionate, why, and when might that change?	Selected response and scope; alternatives considered and rejected; evidence supporting proportionality; uncertainties and dissent; approver and owner; communication plan; completion expectations; explicit triggers, thresholds and review date.

Note: PSII, Patient Safety Incident Investigation; PSIRP, Patient Safety Incident Response Plan; CQC, Care Quality Commission; ICB, Integrated Care Board; MHRA, Medicines and Healthcare products Regulatory Agency; MNSI, Maternity and Newborn Safety Investigations.

4.4. How SELECT Is Used: Structured Narrative, Not Scoring

The proposed workflow places SELECT after immediate safety and mandatory-route screening but before a learning response is commissioned. The final choice remains a human governance decision and is revisited when defined triggers occur. The wider incident-response sequence is described in Section 6.

SELECT is a structured qualitative deliberation, not a scoring system. Each domain is answered in a short factual narrative using the information available at the decision point. The domains are not assigned points, weights or red/amber/green ratings. No total is calculated and no numerical threshold automatically requires or excludes a PSII. This design avoids false precision and preserves PSIRF's requirement for contextual, proportionate judgement.

Table 3 translates this principle into required practice and explicit prohibitions. Its central safeguard is that completing a form structures the evidence and rationale but cannot itself validate or authorise the decision.

Table 3. Operational rules for qualitative use of PSIRF-SELECT.

Element	Required SELECT practice	What must not happen
Evidence entry	Record the relevant fact, source, uncertainty or explicit information gap in words.	Do not convert narrative evidence into unsupported points.

Continued

Six domains	Consider every domain and explain why each matters—or does not materially alter the decision.	Do not omit a domain because it would complicate a preferred outcome.
Response comparison	Compare at least two plausible responses where possible against the learning question, system boundary, engagement needs and existing improvement.	Do not select the most intensive response automatically because harm was severe, or the least intensive because capacity is constrained.
Decision authority	An authorised multidisciplinary group makes and approves the decision, records dissent and declares relevant conflicts.	The form, facilitator or a software implementation must not make the decision.
Decision output	Record the selected response, scope, rationale, rejected alternatives, owner, communication plan, review date and triggers.	Do not treat completion of the form as evidence that the decision is correct or validated.

The framework is completed in two passes. The first pass identifies non-negotiables, information gaps and people who must be involved. The second pass compares plausible response types against the stated learning question, engagement commitments, system boundary and current improvement. A response is proportionate when it is sufficient to answer the important question and support improvement without unnecessary delay, burden or duplication.

When direct involvement is not available before the initial decision. Communication or access barriers must prompt reasonable support—such as interpretation, translation, accessible formats or an advocate—rather than be treated as a refusal. The record states contact attempts, the reason direct involvement is declined, delayed or not yet possible, any known questions or preferences, and whether views among family members differ. It must not assume that one family view represents all those affected. When an initial decision cannot reasonably wait, it is explicitly provisional, with a named owner and date for renewed contact and a trigger to reconsider the response if later engagement adds a material question or changes the appropriate scope.

When capacity prevents the preferred response. The record states: 1) the preferred response and why it was judged appropriate; 2) the unmet capability or capacity; 3) the accountable person or body to whom the constraint was escalated; 4) the interim safety or learning mitigation; and 5) the response/review date and trigger. If a different response is used, the residual risk, the person accepting it and the reconsideration condition are recorded. A capacity constraint must not be re-labelled as low learning potential.

1) Confirm Gate 0 and list parallel routes, urgent controls and responsible owners.

2) Define the unit of decision: single event, cluster, safety issue or emerging risk.

3) Complete all six SELECT domains using the minimum necessary information.

4) Where local choice remains, compare at least two plausible local responses.

When a nationally specified response applies, record that required component first and then determine whether a complementary local response has a distinct justification; do not add a second response merely to complete SELECT. Use a preliminary assessment when material information is insufficient.

5) Conduct an authorised multidisciplinary deliberation, actively inviting patient/public and cross-system perspectives where relevant.

6) Record the selected response, rejected alternatives, evidence, uncertainty, dissent, owner, approver, engagement plan and review triggers.

7) Communicate the decision to those affected, commission the work and re-visit when a trigger occurs.

4.5. Candidate Outputs

Table 4 lists candidate outputs that may follow SELECT deliberation. These are options rather than a hierarchy: the appropriate response is the one that best addresses the stated learning question, system boundary and engagement needs while avoiding unnecessary duplication.

Table 4. Candidate learning-response outputs and safeguards.

Output	When it may fit	Safeguard
Patient safety incident investigation (PSII)	A significant system risk and important unanswered questions justify a defined, system-based investigation; the event can realistically generate new learning.	Do not use severity alone as the trigger. Define scope, independence, expertise and engagement.
After action review (AAR)	A team can learn promptly by reflecting on expected work, what occurred, what helped/hindered and what should change.	Requires skilled facilitation and psychological safety; not appropriate where participants cannot speak safely.
Swarm huddle	Very timely, local learning is possible soon after an event and operational details may otherwise be lost.	It is not a substitute for wider analysis when the system boundary or learning question is broader.
Multidisciplinary team review	The question spans professional perspectives or a pathway and can be addressed through structured collective review.	Include people beyond the immediate team when dependencies require it.
Thematic review	A cluster, recurring pattern or broader safety issue is more informative than treating events separately [30].	Define case set, time window, classification and method; individual engagement needs still remain.
Targeted case-record review/audit/data analysis	The question is specific and can be answered reliably from records or existing data.	Recognise the limits of documentation and consider work-as-done evidence.
Preliminary assessment	Essential facts or perspectives are missing, preventing a defensible choice.	Time-limit the work; specify questions, owner and date. Avoid turning it into an ungoverned full investigation.
No additional individual learning response	The mechanism is well understood, effective improvement is active and monitored, and the event adds no material new learning.	Still provide care, record, engage, meet obligations and include the event in monitoring. State reconsideration triggers.

Continued

Cross-organisational/ coordinated response	The learning question and control span organisational boundaries.	Agree lead, terms, information governance, independence, contributions and escalation with ICB/partners.
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Note. AAR, After Action Review; ICB, Integrated Care Board; MDT, multidisciplinary team; PSII, Patient Safety Incident Investigation.

4.6. Minimum Decision Record

A completed SELECT record should be concise enough for operational use and rich enough for later review. The proposed minimum dataset is listed below; the complete reporting checklist is provided in **Appendix B (Table B1)**. **Appendix C (Table C1)** shows the principal source or design basis for each proposed protected-core field.

- event/cluster/safety-issue identifier and decision date;
- immediate actions and parallel routes, with owners;
- participants, roles, conflicts and approving authority;
- summary evidence under all six domains;
- the precise learning question;
- options considered and why each was accepted or rejected;
- selected response, scope, owner, required capability and expected timescale;
- where capacity prevents the preferred response: preferred option, unmet capability, accountable escalation recipient, interim mitigation, response/review date and trigger, and any residual risk acceptance;
- direct-involvement status, contact attempts or reason involvement is unavailable, questions and preferences of patients, families and staff, required communication/accessibility support, any provisional status and the trigger for reconsideration;
- equity and accessibility considerations;
- uncertainties, dissent or minority view;
- communication commitment; and
- review date and explicit triggers for reconsideration.

5. Three Worked Synthetic Cases

Fictional examples only. Every person, organisation, service, number, technology, timeline and event below is invented. The cases are not composites and are not adapted from the author’s employers or any identifiable healthcare incident. They demonstrate decision logic only and should not be used as clinical or legal precedent.

The cases are deliberately simplified calibration examples. They are designed to make the SELECT reasoning visible, not to reproduce the full uncertainty, documentation volume or competing pressures of a real incident. Each example shows all six domains, plausible alternatives, a human-approved outcome and explicit triggers for reconsideration.

5.1. Synthetic Case A—Outcome: PSII

Fictional situation: At an invented acute provider, a patient experiences temporary harm after an infusion is delivered using a device profile that does not match a newly introduced electronic order set. Staff stop the infusion and the patient recovers. Initial checking suggests an unexpected interaction among the prescribing configuration, a device-library update, local contingency practice and training across two departments. The organisation has no existing investigation or improvement programme covering this combined configuration.

Table 5 applies all six SELECT domains to this fictional event. The decisive considerations are the important unanswered system question, the novel cross-functional mechanism and the need for expertise across a broad system boundary.

Table 5. Application of the six SELECT domains in synthetic case A.

SELECT domain and meaning	Synthetic case assessment
S—Specified requirements and immediate safety	Immediate care and device checks are completed; the event is recorded; Duty of Candour is considered and communication begins. A medical-device safety report to MHRA is screened and assigned. The local PSIRP identifies digital/medication-system interfaces as a priority. No national route replaces the local learning response.
E—Existing knowledge, evidence and improvement activity	Separate risks involving prescribing and devices are known, but the combined failure mechanism and effectiveness of current controls are not understood. No monitored improvement directly addresses it.
L—Learning questions and potential	Unanswered question: How did the configuration, implementation process and workarounds interact to permit the mismatch, and what system controls can prevent recurrence across affected services? The incident can plausibly generate new, transferable learning.
E—Engagement and equity	The patient asks how the mismatch passed existing checks. Staff request a psychologically safe process because the workaround had become normalised. Communication adjustments and representation from both departments are recorded; no differential population impact is yet known and this remains an explicit question.
C—Context, complexity, capacity and coordination	The boundary spans digital, pharmacy, clinical engineering, nursing, medical staff, procurement/vendor configuration and governance. Specialist human-factors and device expertise and sufficient independence are required.
T—Type, transparent rationale and triggers for reconsideration	Selected: PSII with a defined systems scope and coordinated MHRA reporting. Alternatives rejected: a local AAR alone would be too narrow; a thematic review is premature because the combined mechanism is not yet known. Review triggers include evidence of wider distribution, a national safety alert or additional affected services.

Note. All content is wholly synthetic and does not represent any real patient, staff member, organisation or incident.

Why PSII is proportionate. The decision is driven by important new system learning and a complex cross-functional boundary—not by harm severity alone. The external device route runs in parallel and informs coordination; it does not replace the PSII.

Table 6 records the resulting human-approved decision, the alternatives considered and the circumstances that would require reconsideration. It demonstrates that SELECT produces a transparent narrative record rather than a score.

Table 6. Synthetic case A decision record and reconsideration triggers.

Decision-record field	Synthetic entry
Unit and learning question	One configuration-interaction event: how did the electronic order set, device library, implementation process and workarounds combine to permit the mismatch?
Plausible options	PSII; multidisciplinary review; local AAR; preliminary assessment; coordinated product-safety reporting.
Human-approved selection	A defined-scope PSII plus coordinated MHRA/product-safety activity.
Why alternatives were not selected alone	An AAR or multidisciplinary review alone would be too narrow for the cross-functional mechanism. Product reporting answers a surveillance question but does not replace local system learning.
Scope and ownership	Digital, pharmacy, clinical engineering, affected clinical services and relevant product expertise; named investigation lead and authorised approver.
Reconsideration triggers	Evidence of wider distribution, additional affected services, a national alert, material new harm or information changing the system boundary.

Note. PSII, Patient Safety Incident Investigation; MHRA, Medicines and Healthcare products Regulatory Agency.

5.2. Synthetic Case B—Outcome: Thematic Review

Fictional situation: Over a hypothetical six-month period, an invented community-and-acute pathway records eleven reports involving delayed follow-up of diagnostic results after transfers between services. Individual events differ and most cause no or low harm. An initial scan suggests recurring hand-off, ownership and electronic-worklist themes. Several one-off local discussions have occurred, but no cross-case synthesis has been undertaken.

Table 7 applies SELECT to a pattern of related fictional events. Here the correct learning unit is the cluster rather than any single incident, and the key need is to understand recurring conditions across organisational interfaces.

Table 7. Application of the six SELECT domains in synthetic case B.

SELECT domain and meaning	Synthetic case assessment
S—Specified requirements and immediate safety	Immediate outstanding results are clinically reviewed and patients are contacted as required. Events are recorded and Duty of Candour is considered case by case. The local PSIRP includes transitions and diagnostic follow-up as priorities. No single nationally specified investigation route applies to the invented set.
E—Existing knowledge, evidence and improvement activity	The broad risk is known and local teams have made isolated changes, but the pattern across settings, populations and interfaces is not understood. Existing measures are fragmented and cannot show whether the changes work across the pathway.
L—Learning questions and potential	Unanswered question: What recurring system conditions allow ownership of results to become ambiguous during transitions, for whom, and at which interfaces? Learning requires comparison across cases rather than a deep reconstruction of one event.

Continued

E—Engagement and equity	Patients describe uncertainty about who would contact them. Staff from both settings identify conflicting assumptions. The review will sample involvement across services and test whether language, digital access, disability or continuity of care creates unequal risk.
C—Context, complexity, capacity and coordination	The boundary crosses provider teams and commissioning relationships. Data definitions and information governance must be agreed. An ICB-supported coordinator and improvement analyst are needed.
T—Type, transparent rationale and triggers for reconsideration	Selected: thematic review of a defined case set, combined with pathway mapping and targeted engagement. Alternatives rejected: eleven separate PSIIIs would duplicate effort and obscure the common system; a single AAR would not represent the pathway. Triggers include evidence of a novel catastrophic mechanism, a national requirement or inability to obtain cross-system data.

Note: All content is wholly synthetic and does not represent any real patient, staff member, organisation or incident.

Why thematic review is proportionate. The learning unit is the pattern, not one incident. The selected response is more likely to reveal recurring conditions, population differences and control weaknesses while avoiding duplicated investigations.

Table 8 shows how the thematic review is distinguished from multiple separate PSIIIs, a single-event investigation or an audit alone. The record also makes coordination and data-access dependencies visible.

Table 8. Synthetic case B decision record and reconsideration triggers.

Decision-record field	Synthetic entry
Unit and learning question	A defined six-month cluster: where and for whom does ownership of diagnostic-result follow-up become ambiguous across the pathway?
Plausible options	Eleven separate PSIIIs; one selected-case PSII; thematic review; pathway AAR; targeted audit/data analysis.
Human-approved selection	Thematic review of the case set, combined with pathway mapping, targeted engagement and supporting data analysis.
Why alternatives were not selected alone	Separate PSIIIs would duplicate work and obscure the common pattern. One event would not represent the system. An AAR or audit alone would not adequately combine cross-case, work-as-done and engagement evidence.
Scope and ownership	Defined services and time window, agreed case criteria, ICB-supported coordination, improvement analyst, patient/family and staff involvement.
Reconsideration triggers	A novel catastrophic mechanism, a nationally specified route, inability to obtain cross-system evidence or a case requiring distinct independent investigation.

Note: AAR, After Action Review; ICB, Integrated Care Board; PSII, Patient Safety Incident Investigation.

5.3. Synthetic Case C—Outcome: No Additional Individual Learning Response

Fictional situation: An invented provider records another delayed dose of a time-

critical medicine during transfer between wards. The patient is assessed and experiences no lasting harm. A completed systems review two months earlier established the mechanism; a funded improvement programme is active, with named ownership, weekly process measures and evidence that reliability is improving but has not yet reached the agreed target. The new event matches the known mechanism and reveals no new population, interface or failure mode.

Table 9 applies SELECT to a fictional event for which the mechanism is already known and measured improvement is active. The framework therefore tests whether an additional individual learning response would add material knowledge rather than assuming that every event requires a new investigation.

Table 9. Application of the six SELECT domains in synthetic case C.

SELECT domain and meaning	Synthetic case assessment
S—Specified requirements and immediate safety	The patient is assessed, treatment is corrected and the event is recorded. Duty of Candour and communication are addressed. No nationally specified or external investigation route is triggered in this fictional example.
E—Existing knowledge, evidence and improvement activity	The mechanism, contributory factors and control weaknesses are documented. Improvement has an accountable owner, defined actions and current measures. The event is consistent with the residual risk anticipated during implementation.
L—Learning questions and potential	No new learning question is identified after engagement and review. A duplicate individual investigation is unlikely to add knowledge or accelerate the existing programme. The event is still useful as monitoring data.
E—Engagement and equity	The patient asks whether the prior learning is actually producing change. The organisation explains the active programme, apologises as appropriate, offers involvement and records the question as an evaluation requirement. The event is checked for any differential impact not visible in aggregate data.
C—Context, complexity, capacity and coordination	The issue sits within the already defined transfer pathway. Capacity is directed to completing and evaluating improvement, not to repeating the same investigation. This is documented as a learning choice, not merely a resource-saving decision.
T—Type, transparent rationale and triggers for reconsideration	Selected: no additional individual learning response beyond recording, engagement, local review and inclusion in improvement monitoring. Alternatives rejected: duplicate PSII and AAR would repeat known analysis. Triggers for fresh deliberation include deterioration in measures, a different failure mechanism, severe or repeated harm, unequal impact, patient/family questions not answerable from existing work, or failure of actions by the review date. A trigger requires reconsideration; it does not predetermine the next response.

Note: All content is wholly synthetic and does not represent any real patient, staff member, organisation or incident.

Why “no additional response” is not “do nothing”. Care, openness, recording, engagement, monitoring, improvement ownership and reconsideration remain mandatory. The decision only avoids duplicating an analysis that is unlikely to generate new learning.

Table 10 documents the residual actions that remain required and the triggers

for renewed deliberation. The example is intentionally included to show that avoiding duplicate analysis is compatible with continued engagement, monitoring and improvement accountability.

Table 10. Synthetic case C decision record and reconsideration triggers.

Decision-record field	Synthetic entry
Unit and learning question	One further event matching a recently established mechanism: does it reveal any new failure mode, affected group or failure of the improvement programme?
Plausible options	Duplicate PSII; AAR; targeted record check; inclusion in improvement monitoring; no additional individual learning response.
Human-approved selection	No additional individual learning response; continue care, openness, local checking, engagement and measured improvement monitoring.
Why alternatives were not selected	The mechanism and controls were already established and the new event added no material learning. Repeating the same analysis would divert effort from implementation and evaluation.
Scope and ownership	Existing improvement owner records the event, checks fidelity and equity measures, answers the patient's question and reports through established governance.
Reconsideration triggers	Deteriorating measures, a different mechanism, unequal impact, repeated or severe harm, unanswered patient/family questions or failure to implement agreed controls. These trigger a new human deliberation, not an automatic PSII.

Note: AAR, After Action Review; PSII, Patient Safety Incident Investigation.

5.4. Cross-Case Comparison

Table 11 compares the three outcomes. The cases differ because their learning states differ: an important mechanism is unknown in case A, a pattern requires cross-case synthesis in case B, and the mechanism is already known with active improvement in case C.

Table 11. Comparison of the three wholly synthetic SELECT decisions.

Synthetic case	Learning state	Selected outcome	Decisive reason
A—configuration interaction	Important mechanism unknown	PSII	New system learning requires defined cross-functional investigation.
B—result follow-up cluster	Pattern suspected across cases	Thematic review	The cluster, not one event, is the correct learning unit.
C—delayed medicine during transfer	Mechanism known; measured improvement active	No additional individual response	Duplicate analysis adds little; engage, monitor and revisit on explicit triggers.

Note: PSII, Patient Safety Incident Investigation.

6. How Organisations and Processes Fit Together in England

The incident-management landscape can appear confusing because different organisations answer different questions. The provider asks what happened, what can be learned and improved, and how those affected should be supported. Regulators assess compliance and quality. Independent investigators identify national

system learning. Professional regulators protect the public in relation to registrants' fitness to practise. Coroners investigate deaths and may issue Prevention of Future Deaths reports. Complaints, claims, medicines/device surveillance, safeguarding and criminal processes have separate legal or administrative purposes.

The organisations do not form one linear investigation chain. Several routes may start at the same time because they answer different questions. **Table 12** presents the usual functional stages and shows the narrow point at which SELECT is proposed to operate: selection of the local learning response after urgent and mandatory screening.

Table 12. Functional stages of incident response and the proposed position of SELECT.

Stage	Primary lead	Interaction with other parties	Position of SELECT
1 Care and immediate control	Provider clinical and operational teams	Patients/families are supported; safeguarding, emergency escalation and evidence preservation begin where relevant.	Not yet used. Immediate care and mandatory action must not wait.
2 Record and recognise	Provider patient-safety system	Local records and LFPSE support intelligence; staff and those affected may identify additional concerns or questions.	The event, cluster or safety issue becomes a potential decision unit.
3 Screen non-negotiable and parallel routes	Provider authorised safety/governance lead	Consider PSIRP, Duty of Candour, safeguarding, CQC notification, MNSI, MHRA, coroner, police and other applicable routes; allocate owners.	Gate 0 records these routes but cannot cancel, delay or merge them.
4 Select the local learning response	Authorised multidisciplinary provider group	Include clinical, safety, improvement, engagement and patient/public perspectives; involve ICB or partner organisations when boundaries cross.	This is SELECT's principal operating point.
5 Commission and conduct	Named learning-response lead	Engage those affected; coordinate expertise, independence, information governance and external processes.	The SELECT record supplies scope and rationale; it does not conduct the review.
6 Improve, communicate and oversee	Provider governance and improvement owners	Share findings and actions; ICB provides supportive oversight; CQC regulates; national bodies may use relevant learning.	Recorded triggers require reconsideration if the evidence, risk or system boundary changes.

Note: CQC, Care Quality Commission; ICB, Integrated Care Board; LFPSE, Learn from Patient Safety Events; MHRA, Medicines and Healthcare products Regulatory Agency; MNSI, Maternity and Newborn Safety Investigations; PSIRP, Patient Safety Incident Response Plan.

Table 13 explains the principal actors in plain language and states each boundary with SELECT. Its main message is that SELECT coordinates awareness of relevant routes but does not apply their legal or regulatory tests.

Table 13. Principal organisations, processes and boundaries with PSIRF-SELECT.

Acronym/actor	Plain name	Role and when relevant	Boundary with SELECT
DHSC	Department of Health and Social Care	Sets national policy and supports ministerial accountability. Government plans to abolish NHS England and transfer functions by March 2027, subject to Parliament [31].	Policy context; not a local case selector.
NHS England	National NHS body during transition	Publishes PSIRF, standards, proportionate-response guidance, toolkit, LFPSE and oversight expectations [1]-[4] [32].	SELECT must remain subordinate to current national guidance and be updated if responsibilities change.
ICB	Integrated Care Board	Strategic commissioner and supportive system overseer; helps coordinate cross-organisational learning, expertise and information [3] [11].	Invite or escalate when the system boundary, ownership or resources cross providers.
Provider / Trust	Organisation delivering care	Owens immediate care, local recording, Duty of Candour, engagement, PSIRP, learning-response selection, improvement and governance.	Primary operational home for SELECT and owner of the final decision.
Patients, families and staff	People affected by the incident	Provide essential questions, experience and knowledge; must be treated compassionately and involved appropriately [20]-[22] [33].	Their questions and needs are inputs to selection, not merely recipients of the outcome.
PSP	Patient Safety Partner	Can participate in safety committees, improvement, training and investigation oversight [34].	May provide a patient/public perspective in governance; does not substitute for direct engagement with those affected.
CQC	Care Quality Commission	Independent regulator of health and adult social care providers; assesses safety, learning, governance and compliance and receives statutory notifications [35] [36].	CQC does not routinely choose the provider's PSIRF response; compliance evidence may shape governance.
HSSIB	Health Services Safety Investigations Body	Independent arm's-length body conducting national, no-blame systems investigations and sharing learning across England [37].	Its investigations and recommendations may supply existing knowledge or a parallel national process.
LFPSE	Learn from Patient Safety Events	National service for recording and analysing patient-safety events; supports local and national intelligence [32].	SELECT uses identifiers/intelligence but does not duplicate the reporting system.
MNSI	Maternity and Newborn Safety Investigations	CQC-hosted independent, standardised and family-focused investigation programme for qualifying maternity/newborn cases [38].	Screen relevant events; coordinate local learning and avoid duplication while meeting programme requirements.

Continued

MHRA	Medicines and Healthcare products Regulatory Agency	Monitors medicines and medical-device safety; Yellow Card receives suspected adverse reactions and device incidents [39].	Report applicable product issues in parallel; the report does not automatically settle the local learning method.
NHS Resolution	NHS claims and resolution body	Manages relevant claims and uses claims data to support safety learning [40].	Claims learning is an evidence source; claims and PSIRF have different purposes and timescales.
Coroner / PFD	Coroner and Prevention of Future Deaths report	Investigates specified deaths; must issue a PFD report where circumstances create a risk of future deaths [41].	Plan lawful information sharing and coordination. SELECT neither predicts nor replaces the coronial process.
GMC / NMC / HCPC / GPhC	Professional regulators	Set standards and address serious fitness-to-practise concerns for their registrants [42]-[46].	Separate system learning from individual regulatory thresholds; use Being Fair principles and referral guidance.
PHSO	Parliamentary and Health Service Ombudsman	Final stage for unresolved complaints about the NHS in England and other public bodies [47].	Complaints questions may inform learning; the Ombudsman route remains separate.
PSC	Patient Safety Commissioner for England	Independent champion for patient voice in the safety of medicines and medical devices; cannot investigate individual cases [48].	Relevant to systemic medicine/device themes and patient voice, not routine local case selection.
Safeguarding bodies	Provider/ICB/local-authority safeguarding routes	Protect children and adults at risk and coordinate statutory safeguarding responses.	Screen immediately and assign ownership; do not delay safeguarding while deciding a learning response.
Police	Criminal investigation	A 2024 memorandum describes coordination where suspected criminal activity may have contributed to death or serious life-changing harm; the vast majority of incidents remain within PSIRF without invoking it [49].	Use the high threshold and agreed liaison; SELECT does not determine criminality.

Note: Abbreviations are expanded in the table and in **Appendix A**. Organisational roles and structures should be checked against current official guidance before implementation.

A consolidated plain-English glossary of the organisations, processes and abbreviations used in this section is provided in **Appendix A (Table A1)**.

The Boundary Rule

Different questions, coordinated processes. PSIRF learning asks how care systems can be understood and improved. Regulation asks whether standards are met. Professional fitness-to-practise asks whether a registrant presents a current public-protection concern. Coroners investigate deaths; complaints seek resolu-

tion; claims address legal liability/compensation; MHRA monitors product safety; police investigate suspected crime. SELECT records and coordinates relevant routes but does not merge their tests, evidence standards or outcomes.

7. Safeguards and Foreseeable Failure Modes

Table 14 anticipates foreseeable misuse and implementation failure. The safeguards protect the qualitative, multidisciplinary and reviewable character of SELECT and should form part of any co-design, training and pilot protocol.

Table 14. Foreseeable failure modes and proposed safeguards.

Failure mode	How it may appear	Design/implementation safeguard
SELECT becomes a score	Users assign points and treat a threshold as the answer.	Prohibit numerical totals in the prototype; audit records for score-like use; require narrative rationale and human approval.
Harm severity dominates	Severe outcome automatically triggers PSII or no-harm event is dismissed.	Separate outcome from learning potential; record the learning question and test outcome bias in training/audit [19].
Capacity is disguised as proportionality	A useful response is rejected because staff are unavailable, but this is documented as low learning.	Record capability and capacity explicitly; escalate unresolved resource risk; distinguish desirability from feasibility.
Engagement is tokenistic	Patient/family questions are added after the response has been fixed.	Complete the engagement domain before approval; record questions and how they affected scope; offer reconsideration where new questions arise.
Equity becomes a tick box	No analysis of who is affected or missing from the data.	Use population and accessibility prompts; monitor differences in selected responses and involvement; include PSP/equality expertise.
Preliminary assessment drifts	A preliminary assessment becomes an ungoverned investigation with no deadline.	Specify only the missing questions, owner and review date; prohibit recommendations before the response decision unless urgent controls are required.
No additional response is interpreted as no action	Recording, communication or monitoring is omitted.	Make the mandatory residual actions visible and audit them; require existing improvement owner, measures and triggers.
Parallel processes are conflated	A regulatory or employment process substitutes for systems learning, or PSIRF is used to avoid referral.	Use the Gate 0 route checklist and boundary statement; assign separate owners and lawful information-sharing plan.
Documentation creates burden	The form delays action and duplicates existing systems.	Co-design for minimum data, reuse identifiers and existing fields, time the task, and permit short forms for low-complexity decisions.
Local adaptation removes core safeguards	A Trust retains the acronym but deletes engagement, alternatives or review triggers.	Define a protected core dataset and separately label locally adaptable fields; version-control changes.

Information Governance and Psychological Safety

The decision record should contain the minimum necessary information and use existing authorised systems. It should not reproduce sensitive clinical detail where a link to the source record is sufficient. Information sharing across organisations or with external bodies requires the appropriate legal basis, agreements and access controls. The need for openness must be balanced with confidentiality and protected disclosure arrangements.

Staff participation should be supported and psychologically safe. SELECT should not be used as an interview template for testing individual credibility or as a performance-management instrument. Where there are concerns about conduct or fitness to practise, the organisation should use the relevant fair and professional processes while maintaining the systems-learning purpose [42]–[46] [50].

8. Evaluation and Implementation Roadmap

PSIRF-SELECT can move immediately into responsible critique, co-design and simulation. It should not move directly from publication to ungoverned routine adoption or be relied upon as the sole authority for a live decision. A staged programme is needed to determine whether the gap is real in varied settings, whether the tool is usable, whether different teams reach defensible decisions and whether the record improves transparency without producing new burden or inequity.

8.1. Responsible Early Use before Validation

Unvalidated does not mean unusable for learning and development. NHS organisations, ICBs, Patient Safety Partners, educators and researchers are encouraged to examine and test the proposal in controlled ways. Early use should generate evidence and improve the framework rather than imply that its effectiveness has already been established.

Table 15 distinguishes four responsible early-use modes. The boundaries become progressively stronger as the activity moves from critique and simulation toward shadow testing and a prospective pilot.

Table 15. Responsible early-use modes before validation.

Early-use mode	Appropriate activity	Required boundary
Critique and co-design	Review the six domains, wording, omissions, burden, equity implications and fit with existing local governance.	Record feedback and conflicts; participation does not imply endorsement.
Synthetic-case simulation	Use the published fictional cases or newly invented scenarios to test comprehension, timing, facilitation, decision rationale and failure modes.	Use no real patient or staff information; the exercise must not be represented as validation.
Shadow or retrospective testing	Complete SELECT alongside an existing, already governed decision or apply it to locally authorised de-identified historical material; compare what it adds or changes.	SELECT must not replace the authorised process; local information-governance and service-evaluation approvals apply.

Continued

Prospective pilot	Use within an organisation's existing authorised PSIRF decision process with trained facilitators, explicit oversight, feedback, review dates and stopping rules.	The human governance group retains authority; no score, automation or unsupported threshold; material concerns trigger review or suspension.
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Note: ICB, Integrated Care Board; PSIRF, Patient Safety Incident Response Framework.

The practical position is therefore an invitation with safeguards: use SELECT to structure discussion, compare it with current practice and report what works or fails. Do not present it as NHS guidance, a validated instrument or a substitute for the organisation's accountable decision-making arrangements.

Table 16 sets out the proposed evaluation pathway. Each phase is designed to answer a different question, beginning with governance and content validity before progressing to feasibility, reliability, outcomes and stewardship.

Table 16. Staged evaluation and implementation roadmap.

Phase	Proposed activity	Primary questions/outputs
0) Pre-pilot governance	Confirm intellectual-property/name issues; patient/public review; legal/IG review; map current national changes; publish version control and conflict-of-interest statement.	Governance pack; protected core fields; revised prototype.
1) Co-design	Workshops with patient/family representatives, PSPs, safety specialists, clinicians, improvement teams, ICB oversight and under-represented settings.	Content validity; language clarity; unacceptable burden/risks; missing domains.
2) Cognitive and simulation testing	Think-aloud use with synthetic cases of varied harm, complexity and uncertainty; deliberately test outcome bias and no-additional-response decisions.	Comprehension, time, navigation, decision rationale quality and failure modes.
3) Retrospective feasibility	Apply to de-identified or locally governed historical decisions without changing care; compare SELECT record with existing documentation.	Data availability, completion, added value, discrepancies and training needs.
4) Prospective pilot	Voluntary multi-site use within existing governance; no autonomous decision; independent process evaluation and safety monitoring.	Adoption, time, fidelity, user experience, engagement, equity and unintended consequences.
5) Reliability/validity study	Independent panels assess standardised cases; compare decisions, rationale quality and confidence. Evaluate inter-rater agreement carefully because legitimate contextual variation is expected.	Agreement, reasoning quality, content/construct validity and sensitivity to material new information.
6) Outcome and economic evaluation	Compare documentation, timeliness, duplication, engagement experience, learning quality, action quality and resource use; do not rely on incident counts alone.	Effectiveness, cost/consequence, distributional impact and sustainability.
7) Scale and stewardship	Open specification, training standards, audit guidance, national alignment review and formal change control.	Version stability, local adaptation fidelity and transparent evidence updates.

Note: ICB, Integrated Care Board; IG, information governance; PSP, Patient Safety Partner.

8.2. Candidate Evaluation Measures

- Feasibility: completion rate, median time, missing fields, number and role of participants, and proportion needing preliminary assessment.
- Fidelity: completion of all six domains, documentation of alternatives/uncertainty/triggers, and evidence that engagement occurred before approval.
- Decision quality: independent structured review of relevance, coherence, proportionality, systems orientation and traceability—not whether reviewers personally prefer the same method.
- Reliability: agreement on response category and, separately, agreement on material considerations and learning question; report confidence intervals and expected contextual variation.
- Equity: differences in response selection, engagement and reconsideration by service, population, communication need and protected/inequality characteristics where lawful and appropriate.
- Experience: patient/family/staff perceptions of being heard, clarity of explanation, burden and psychological safety.
- Process outcomes: decision timeliness, duplication, overdue work, cross-system coordination and proportion of decisions revisited appropriately.
- Learning/improvement outcomes: quality and novelty of learning, linkage to improvement, action strength, implementation and evidence of effectiveness.
- Unintended consequences: gaming, over-investigation, under-response, delay, excessive documentation, inequitable application or inappropriate individualisation.

8.3. Invitation to NHS Partners for Phase 2

This paper actively seeks co-design and evaluation partners rather than immediate uncritical adoption. Each organisation would control its own information, approvals and accountable decisions. Participation can begin without sharing identifiable incident data with the author: partners may review the content, run the published synthetic cases, create their own fictional scenarios or compare SELECT with their existing decision process under local governance.

Responsible invitation wording. We invite NHS providers, ICBs, Patient Safety Partners, educators and researchers to critique, co-design and test PSIRF-SELECT through simulation, shadow use or locally governed pilot work. Participation would not imply NHS endorsement. No identifiable patient, staff or incident information should leave approved governance arrangements, and SELECT should not be the sole authority for a live decision.

9. Discussion

9.1. Principal Contribution

PSIRF-SELECT translates a dispersed set of national expectations into a proposed minimum deliberation and decision record. Its contribution is not another hierarchy of harm, a mandatory route or a replacement investigation method. It is a

way of asking whether the selected response is traceable to specified requirements, current knowledge, a meaningful learning question, the needs of those affected, the true system boundary and a transparent rationale.

This design responds directly to HSSIB's call for practical steps and a robust, standard approach while respecting the flexibility at the centre of PSIRF [12]. A standard process need not produce identical outcomes: two providers may reasonably choose different methods when context, available evidence or engagement questions differ. Standardisation should apply to the quality and visibility of the reasoning, not force uniform answers.

9.2. Relationship to Existing Tools

National and local tools are assets, not competitors. SELECT could sit before the NHS learning-response toolkit, documenting why a particular method is commissioned [4]. A Trust could retain its existing flowchart and add the protected SELECT minimum record. Where an existing local form already captures the six domains and the decision trail, replacement would be unnecessary. Evaluation should therefore compare integration, supplementation and no-change options rather than assume that a new standalone form is best.

International frameworks and concise-analysis tools show that proportionate, structured approaches are feasible [51] [52]. Systems frameworks such as SEIPS and the Yorkshire Contributory Factors Framework support analysis of interacting work-system conditions [23] [27]. SELECT is different in function: it selects and documents the response before detailed analysis, although its Context domain is informed by systems thinking.

9.3. Bias Awareness and Traceability

Outcome bias research provides a concrete reason to document how harm severity was used and what evidence supports perceived culpability or learning potential [19]. The author's earlier DEEP SEE conceptual framework similarly emphasised bias-aware, contextual analysis after an event [53]. SELECT uses a narrower lesson at an earlier decision point: require explicit alternatives, uncertainty and a system question so an emotionally salient outcome does not silently determine the method. DEEP SEE is not incorporated into SELECT and has not been used as validation evidence.

The author's DEEP SEE-MIRROR work on structured and auditable AI reasoning may be relevant to a distant digital implementation pathway [54]. However, this manuscript proposes a human deliberation process. Automated response selection, predictive scoring or language-model recommendations should not be introduced without separate evidence, governance, human-factors testing, bias evaluation, data protection and meaningful human control.

9.4. Strengths

- The proposal is explicitly anchored to current PSIRF guidance and acknowl-

edges existing local tools.

- A direct national gap signal from HSSIB is distinguished from indirect empirical support.
- Engagement, equity, capacity, alternatives, uncertainty and review triggers are visible rather than assumed.
- Three synthetic cases demonstrate that the framework can support different outcomes without hospital data.
- The minimum record creates a basis for empirical testing, audit and revision.

9.5. Limitations

- The targeted literature and policy review was single-author and limited to accessible sources; it cannot establish exhaustive novelty.
- The framework is conceptually derived and has not undergone patient/public co-design, content validation, reliability testing or prospective evaluation.
- The minimum functional composition, approval safeguard, provisional-engagement rule, capacity-escalation record and protected-core field classification are author-proposed design safeguards requiring co-design and testing; they are not nationally mandated governance arrangements.
- The mnemonic may oversimplify complex governance and may create documentation burden or false assurance.
- Public local documents may not reflect actual work-as-done, unpublished tools or implementation outcomes.
- Synthetic cases demonstrate internal logic only; they cannot establish feasibility, safety, fairness or impact.
- Organisational roles and national structures are changing. In particular, the planned transfer of NHS England functions to DHSC means descriptions require updating before publication or implementation [31].
- The proposal was developed outside the NHS England policy process and must not be represented as official NHS guidance or endorsement.

9.6. Implications for Policy, Practice and Research

For policy, the proposal identifies a candidate minimum record that could be compared with forthcoming national work rather than promoted prematurely. For practice, it offers a language for reviewing local decision processes and explaining choices to those affected. For research, it defines a testable intervention, mechanisms and outcomes. The most important next question is not whether the acronym is memorable, but whether the process changes who is heard, what evidence is considered, how uncertainty is handled and whether the resulting learning contributes to safer care.

10. Conclusions

PSIRF created necessary flexibility to focus incident response on learning and improvement rather than rigid harm thresholds. That flexibility increases the im-

portance of transparent, consistent and reviewable judgement. PSIRF-SELECT is a proposed six-domain deliberation and documentation framework designed to make that judgement visible while preserving local context and human authority.

The evidence reviewed supports the existence of a practical implementation need but does not prove that SELECT is the correct solution. Existing local flowcharts and tools must be recognised; the framework's defensible novelty lies in its proposed integrated minimum record and evaluation pathway. The next stage should therefore be co-design and staged validation—not claims of adoption, effectiveness or NHS endorsement.

Acknowledgements

During preparation of this manuscript, the author used OpenAI ChatGPT (web application; accessed August–September 2026) for evidence organisation, drafting support, language editing and document formatting. The author reviewed and edited the outputs and accepts full responsibility for the final manuscript. No generative AI-created figures or research data are included in the revised manuscript.

Ethics Approval

Ethics approval was not required because this conceptual manuscript involved no human participants, identifiable personal data, patient records or organisational incident data.

Data Availability

No participant-level or organisational datasets were generated or analysed. All documentary sources are publicly accessible and cited. The worked cases are wholly synthetic. **Supplementary Table S1** provides the source-by-source evidence table and maps each source to the SELECT domain(s) or design principle(s) it informed.

Author Contributions

Adel Omar Bataweel: Conceptualisation, methodology, investigation, project administration, writing—original draft, and writing—review and editing.

Conflicts of Interest

The author developed DEEP SEE and DEEP SEE-MIRROR, which are cited in this manuscript. The author declares no financial competing interests.

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Appendix A. Acronyms and Plain-English Glossary

Table A1 provides a reference glossary for the organisations, processes and technical terms used throughout the manuscript.

Table A1. Acronyms and plain-English glossary.

Term	Full name	Plain-English meaning
AAR	After Action Review	Structured team reflection on what was expected, what happened, why and what can be learned.
CQC	Care Quality Commission	Independent regulator of health and adult social care providers in England.
DHSC	Department of Health and Social Care	Government department responsible for national health and care policy and ministerial accountability.
Duty of Candour	Statutory/professional openness duties	Requirements to be open and honest when specified safety incidents occur; the exact statutory test must be applied.
GMC	General Medical Council	UK regulator for doctors and, under current arrangements, specified medical associate professions.
GPhC	General Pharmaceutical Council	Regulator of pharmacists, pharmacy technicians and registered pharmacies in Great Britain.
HCPC	Health and Care Professions Council	UK regulator for 15 health and care professions.
HSSIB	Health Services Safety Investigations Body	Independent national body for system-focused patient-safety investigations in England; successor to HSIB for national work.
ICB	Integrated Care Board	Statutory NHS organisation responsible for strategic commissioning and system leadership in an integrated care system.
ICS	Integrated Care System	Partnership of organisations planning and delivering joined-up health and care in a geographical area.
LFPSE	Learn from Patient Safety Events	National NHS event-recording and analysis service.
MDT	Multidisciplinary team	People from different professional or organisational perspectives working together.
MHRA	Medicines and Healthcare products Regulatory Agency	UK regulator/monitor for medicines, medical devices and other healthcare products; runs Yellow Card.
MNSI	Maternity and Newborn Safety Investigations	CQC-hosted independent programme for qualifying maternity/newborn cases.
NHS	National Health Service	Publicly funded health service; PSIRF in this paper refers to England.
NMC	Nursing and Midwifery Council	UK regulator for nurses and midwives and regulator for nursing associates in England.
PDF	Prevention of Future Deaths report	Report a coroner must issue to a person/body able to act where circumstances create a risk of future deaths.
PHSO	Parliamentary and Health Service Ombudsman	Final stage for unresolved complaints about the NHS in England and specified public bodies.
PSII	Patient Safety Incident Investigation	Defined system-based investigation under PSIRF where significant risk and potential for new learning justify it.
PSIRF	Patient Safety Incident Response Framework	NHS approach in England to responding to patient-safety incidents for learning and improvement.

Continued

PSIRP	Patient Safety Incident Response Plan	Provider plan describing local priorities and intended responses based on data, engagement and improvement context.
PSP	Patient Safety Partner	Patient/public role contributing to patient-safety governance, improvement and oversight.
PSC	Patient Safety Commissioner	Independent champion for patients in relation to the safety of medicines and medical devices in England.
QI	Quality improvement	Systematic work to test, implement and measure changes intended to improve care.
RCA	Root cause analysis	Family of approaches seeking causes of incidents; simplistic single-root models are inconsistent with modern systems thinking.
SEIPS	Systems Engineering Initiative for Patient Safety	Human-factors framework for understanding interactions among people, tasks, tools, organisation and environment.
SELECT	Specified; Existing; Learning; Engagement/equity; Context; Type/transparent rationale/triggers	Proposed six-domain deliberation and documentation framework in this manuscript.

Appendix B. Minimum Data Set and Reporting Checklist

Table B1 converts the proposed minimum record into a reporting checklist. It is a conceptual specification for co-design and testing, not a validated operational form.

Table B1. Proposed minimum data set and reporting checklist.

Block	Required minimum
Identity	Decision identifier; linked event/cluster/safety issue; service; date; version.
Gate 0	Immediate care/risk controls; recording; Duty of Candour; evidence preservation; nationally specified/external routes and owners; whether distinct local learning remains.
Participation	Decision lead and locally accountable approver; attendees/roles; minimum functional perspectives; alternate/asynchronous input; patient/public input; cross-system partners; conflicts/independence; dissent.
S	Specified national/local requirements and immediate safety position.
E—Existing knowledge, evidence and improvement activity	Existing knowledge; prior learning; controls; improvement owner; measures/effectiveness; material novelty.
L	One or more precise learning questions; intended audience; realistic learning potential.
E—Engagement and equity	Questions, needs and involvement preferences; direct-involvement status, attempts or reason unavailable; accessibility/equity; provisional status; renewed-contact owner and reconsideration trigger.
C	System boundary; complexity; expertise; independence; capability/capacity; data; coordination and information governance.
Capacity escalation	Preferred response; unmet capability/capacity; accountable escalation recipient; interim mitigation; response/review date and trigger; residual risk and acceptance if an alternative is used.
T	Options; selected response; rejected alternatives; rationale; scope; owner; timescale; uncertainty/dissent.

Continued

Communication	Who will be told what, by whom and when; how questions or disagreement can lead to reconsideration.
Review	Review date; measurable triggers; person accountable for checking triggers and recording the outcome.

Note: “Required minimum” denotes the proposed SELECT protected core; it does not mean that every field is individually mandated by NHS England. All fields require co-design and feasibility testing before routine use.

Appendix C. Proposed Protected-Core Field-to-Source Crosswalk

This appendix maps every field in the proposed SELECT minimum record to its principal basis. “N” indicates an explicit national PSIRF requirement or standard; “G” national guidance or an official role/boundary source; “E” empirical or established conceptual evidence; and “D” an author-proposed design safeguard. A D classification is not an NHS mandate. The crosswalk is intended to support audit, version control and future updating during co-design.

Table C1. Proposed SELECT protected-core field-to-source crosswalk.

SELECT record field	Basis and principal source(s)	Reason for inclusion
Decision identifier, date and version	D: proposed audit and version-control safeguard	Enables traceability, later review and consistent updating of the decision record.
Linked event, cluster or safety issue and service	N/G: [1]-[3] [32]	Defines the unit of decision and links SELECT to existing reporting and intelligence systems.
Immediate care and urgent risk controls	N: [1]-[3]	Prevents deliberation about learning method from delaying care or immediate risk reduction.
Event recording	N/G: [1]-[3] [32]	Maintains the national/local event record and supports intelligence, monitoring and learning.
Duty of Candour and compassionate communication	N/G: [1]-[3] [33]	Keeps legal/professional openness and compassionate communication visible but separate from response selection.
Preservation of relevant information	G/D: [2] [3] [47]	Protects material needed for learning and any parallel statutory or external process.
Nationally specified, statutory and external routes	N/G: [2] [3] [36]-[49]	Records non-negotiable or parallel routes before discretionary local learning choices are considered.
Owner for each immediate or parallel action	N/G: [3] [36]-[49]	Makes responsibility visible and reduces delay or mistaken substitution between processes.
Decision lead and accountable approver	N/G: [3]	Locates authority within the provider’s documented governance and oversight arrangements.
Participants, roles and functional perspectives	N/G/D: [3] [34]	Shows that the decision obtained proportionate safety, clinical/operational, improvement and patient/public perspectives.
Competence, conflicts and independence	N/G/E: [3] [15]-[19]	Protects credible challenge, system orientation and freedom from unmanaged conflicts or outcome bias.

Continued

Direct patient, family and staff input	N/G/E: [3] [20]-[22] [33] [34]	Treats the questions and experience of those affected as evidence shaping the response.
Cross-organisational participation	N/G: [3] [11]	Ensures the decision boundary and authority match the pathway when responsibility spans organisations.
Existing local and national knowledge	N/G: [2]-[4]	Avoids unnecessary repetition and identifies what is already understood.
Current controls, improvement owner and measures	N/G: [2]-[4]	Tests whether known improvement is active, reliable and producing the intended effect.
Material novelty and evidence gaps	G/E: [2] [12] [14]-[18]	Distinguishes a genuinely new mechanism, population or control failure from a known issue.
Precise learning question and intended audience	G/E: [2] [12] [14]-[18]	Links the method to an answerable question and the people or system that need the answer.
Realistic learning potential	N/G: [2]-[4]	Tests whether the proposed response can generate actionable system knowledge.
Questions, needs and involvement preferences	N/G/E: [3] [20]-[22] [33] [34]	Supports meaningful, compassionate engagement and avoids tokenistic involvement.
Direct-involvement status, attempts and barriers	N/G/D: [3] [29] [33] [34]	Makes declined, delayed or inaccessible involvement visible and requires reasonable communication support.
Provisional status, renewed-contact owner and reconsideration trigger	D, informed by [3] [33] [34]	Allows a necessary initial decision without treating absent early involvement as permanent closure.
Accessibility, reasonable adjustments and equity impact	G/E: [20]-[22] [29] [33] [34]	Reduces the risk that response selection overlooks communication needs, exclusion or differential impact.
System boundary, interfaces, complexity and work-as-done	N/G/E: [3] [23]-[28]	Aligns the response scope with the sociotechnical system rather than the most proximal act.
Expertise, data, information governance and coordination	N/G/E: [3] [11] [23]-[28]	Tests whether the selected response can be conducted lawfully and credibly across the required boundary.
Required capability and available capacity	N/G: [3] [11]	Separates the desirability of a response from its immediate feasibility.
Capacity escalation: preferred option, unmet capability, recipient, interim mitigation and review trigger	D, informed by [3] [11]	Prevents resource shortage from being relabelled as low learning potential and creates an accountable escalation trail.
Plausible options considered	G/E/D: [2] [4] [19]	Reduces premature closure and makes the effect of evidence and outcome bias reviewable.
Selected response and rejected alternatives	G/E/D: [2] [4] [19]	Creates a transparent explanation of proportionality instead of a score or unexplained route.
Scope, owner, capability and expected timescale	N/G: [2]-[4]	Connects the decision to commissionable work and accountable delivery.
Uncertainty, dissent or minority view	E/D: [15]-[19]	Preserves material disagreement and uncertainty rather than manufacturing false consensus.

Continued

Communication commitment	N/G/E: [3] [20]-[22] [33]	Ensures the decision and its rationale are explained to those affected.
Review date, explicit triggers and accountable checker	G/D: [3] [4]	Makes reconsideration operational when evidence, risk, engagement or improvement performance changes.

Note: The numerical citations correspond to the renumbered reference list. The mapping identifies principal rather than exhaustive sources. It should be rechecked whenever PSIRF guidance or the SELECT protected core is updated.

Appendix D. Supplementary Table S1

https://www.researchgate.net/publication/415566087_PSIRF-SELECT_-Supplementary_Table_S1?channel=doi&linkId=6acc5a05df27da413339983a&showFulltext=true