Birmingham and Solihull Mental Health NHS Foundation Trust

Patient safety incident response plan

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	NAME	TITLE	DATE
Author	Samantha Munbodh	Head of Patient Safety	**July 2026**
Authoriser	Roisin Fallon-Williams	Chief Executive	**July 2026**

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Foreword from a Patient Safety Partner

Patient Safety Partners are people with lived experience of healthcare who work alongside the Trust to improve patient safety. They may bring experience as service users, carers or family members, helping to ensure that learning remains connected to what matters most to people who use mental health services and those close to them.

A patient safety incident can have a lasting impact on the person, their family, carers and others close to them. It can leave people with questions, uncertainty and a need to understand what happened.

For those affected, the response that follows matters. Being listened to, treated with kindness and given honest information can make a real difference. People should not feel that they are simply being managed through a process, or that difficult questions are unwelcome. They should know who they can speak to, what will happen next and how they can be involved.

Lived experience adds an important part of the picture. Records and professional accounts may show what happened, but they may not fully show how care was experienced, where communication broke down or how concerns developed across different services and over time.

This plan should therefore be judged not only by whether reviews are completed, but by whether people feel heard, whether learning leads to visible change and whether care becomes safer as a result.

Patient Safety Partners have a role in keeping these questions in view, offering an independent perspective and helping the Trust understand how its response is experienced by service users, families and carers.

The approach set out in this plan is welcomed. Its value will be seen in how consistently it is put into practice and whether those affected can see that their experiences, questions and concerns have contributed to meaningful learning and change.

What matters most after an incident	
People feel heard	Service users, families and carers are listened to early and respectfully.
Questions shape the response	The concerns of those affected help guide what the Trust needs to understand.

Learning leads to change	The value of the plan will be seen in visible improvement, not only completed reviews.

1.0 Introduction

This Patient Safety Incident Response Plan explains how Birmingham and Solihull Mental Health NHS Foundation Trust responds to patient safety incidents and uses learning to improve care over the next 12 to 18 months. It sets out our priorities, the learning responses we may use, and how learning will be turned into action.

This plan at a glance	
Purpose	To explain how the Trust responds to patient safety incidents and uses learning to improve care.
Timeframe	The plan covers the next 12 to 18 months and will be formally reviewed within 18 months, or sooner if needed.
How we respond	Responses are proportionate, compassionate and focused on learning, improvement and support for those affected.
Who is involved	Service users, families, carers, staff, clinical leaders, system partners and Patient Safety Partners all contribute to learning and improvement.

The plan supports the continued embedding of the national Patient Safety Incident Response Framework (PSIRF). PSIRF asks us to respond proportionately, compassionately and with a clear focus on learning. It helps us look beyond individual actions to understand the wider conditions in which care was delivered.

Our focus is on asking the right questions: what needs to be understood, who should be involved, what support is needed, and which response is most likely to lead to useful learning. The aim is not to find blame, but to understand what needs to change.

Not every incident will need a Patient Safety Incident Investigation. Some require a full systems-based investigation; others may be better understood through an After Action Review, multidisciplinary review, thematic review, case note review or local review. A proportionate response means choosing the approach that best fits the incident and is most likely to lead to improvement.

Proportionate does not mean doing less. It means taking the incident seriously, being clear about the learning needed, and considering harm, potential new learning, existing improvement work, wider themes, and the needs of service users, families, carers and staff.

Compassionate engagement is central to this plan. Service users, families and carers affected by patient safety incidents will be involved early, honestly and respectfully. They will be told what will happen next, offered meaningful opportunities to be involved in ways that are right for them, listened to, and kept informed as learning progresses.

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The following sections describe our services, safety profile, improvement priorities, national requirements and local focus areas. They also explain how responses are overseen, shared and acted on.

This plan should be read alongside the Trust's PSIRF policy and related procedures. The policy describes roles and responsibilities in detail; this plan explains our priorities and how we will respond in practice.

2.0 Our services

Our services at a glance	
Who we support	People across Birmingham, Solihull, the wider West Midlands and beyond for some specialist services.
Our scale	More than 40 sites, around 1.3 million people in our local population, and over 6,000 staff.
What we provide	A broad range of mental health services, including community, urgent, inpatient, specialist, secure, older adult and children and young people's services.
How we use learning	We use learning from incidents, feedback, data and improvement work to understand risks and make care safer.

Birmingham and Solihull Mental Health NHS Foundation Trust provides mental health care and support across Birmingham, Solihull, the wider West Midlands and, for some specialist services, beyond. We work from more than 40 sites, serve a diverse local population of around 1.3 million people across 172 square miles, and employ over 6,000 staff.

The people we support come from many communities and backgrounds. Some areas experience higher deprivation, lower income and unemployment, which can affect health and access to care. Our services therefore need to be practical, inclusive and responsive to local communities.

The Trust is led by a Board of Directors. Day-to-day responsibility for clinical and non-clinical services is delegated to Executive Directors, senior clinicians and managers.

Clinical services are organised into five service areas, led by senior clinical and operational leaders including Associate Directors, Associate Medical Directors, Heads of Nursing and Allied Health Professional leads.

- Specialties, Dementia and Frailty
- Secure Care and Offender Health
- Acute and Urgent Care
- Integrated Community Care Services
- Children and Young People

Trust-wide and local governance arrangements support patient safety by helping us identify risks, respond to concerns, learn from incidents and follow through on improvements.

The Trust's Clinical Governance Committee oversees the governance framework, including patient safety.

3.0 Refreshing our patient safety incident profile

This refreshed plan builds on learning since PSIRF was introduced in the Trust. It does not repeat the original priority-setting process. Instead, current data, learning response themes, staff insight, service intelligence and feedback from people affected by patient safety incidents have been used to check whether our priorities remain right.

Since introducing PSIRF, learning responses have led to improvements in discharge and transition processes, multidisciplinary communication, observation practice, family involvement, clinical guidance, education and governance arrangements. Learning has also informed thematic reviews and wider quality improvement work, so improvements reach beyond individual incidents and strengthen systems of care.

For this refresh, we reviewed patient safety data and learning from the first phase of PSIRF implementation. This included what investigations and other learning responses have told us, where themes continue, where new risks have emerged, and where improvement work is already under way.

The review drew on reported patient safety incidents, completed PSIIs and other learning responses, mortality reviews, complaints, claims, safeguarding information, Freedom to Speak Up themes, quality assurance activity, service risk discussions and relevant national learning. It also considered whether existing priorities were leading to useful learning and improvement, and whether any areas needed to be strengthened, changed or removed.

Learning from all responses is considered alongside incident data, mortality reviews, complaints, safeguarding information, Freedom to Speak Up themes, claims and other intelligence. This helps identify recurring themes, emerging risks and opportunities for improvement. Where patterns are identified, the Trust may commission a thematic review or Patient Safety Incident Investigation to better understand system factors and support organisation-wide improvement.

Staff and clinical leaders contributed by sharing what they were seeing in services, including pressures, recurring themes and areas where safety work was making a difference. This helped balance incident data with practical insight from teams delivering care.

We also reviewed learning about compassionate engagement, family and carer involvement, and inequalities in patient safety. This included whether service users, families and carers affected by incidents had been involved early enough, the questions and concerns of service users, families and carers shaped the learning response, and whether learning led to clear action.

The refresh confirms the need to focus on areas with the greatest opportunity to learn and improve. Some priorities remain because they are still important. Others have been refined to reflect implementation learning, current service pressures and emerging themes. Patient Safety Partners will continue to support future reviews, so service user, family and carer views help shape how priorities develop.

4.0 Our patient safety incident response plan: national requirements

Some patient safety incidents must be reviewed in a specific way because national requirements apply. These include deaths where problems in care are thought more likely than not to have contributed.

Where a Patient Safety Incident Investigation is required, a systems-based approach will be used, focused on learning and improvement, not blame. Investigation numbers will be kept manageable so each one can be completed well and lead to useful action.

The table below summarises the national incident types and the expected response.

National requirements at a glance	
Some responses are required nationally	Certain incidents must be referred, reviewed or investigated in a specific way because national or statutory processes apply.
The Trust still learns locally	Immediate safety actions, support and local learning can begin while external or statutory processes are under way.
Duplication is avoided	Where more than one process applies, reviews will be coordinated so learning is shared and people are not asked to repeat their experience unnecessarily.

National priorities		
Patient safety incident type	**Approach**	**Improvement route**
Incidents in screening programmes	Work with partners to refer cases to the relevant national screening programme team.	Respond to external recommendations and feed actions into improvement work.
Death of a person with a learning disability or autistic person	Refer for a Learning Disabilities Mortality Review (LeDeR) through the ICB or local LeDeR process. Where the person was under Trust care, the Trust will also consider whether a local mortality or patient safety learning response is needed. This may include SJR/SJR Plus, multidisciplinary team review, thematic review or PSII where national PSII criteria are met. LeDeR and Trust learning responses should be coordinated so learning is shared and duplication is avoided.	
Safeguarding incidents involving children, young people or adults with care and support needs, including concerns linked to neglect, abuse, domestic abuse, FGM, Prevent, modern slavery or human trafficking.	Refer to the relevant local authority safeguarding lead through the Trust safeguarding lead. For a domestic homicide or suspected domestic abuse related death, notify the Trust safeguarding team and work with the relevant Community Safety Partnership or local domestic abuse/DHR coordination process so a Domestic Homicide Review decision can be made. The Trust will complete any required Individual Management Review and identify immediate learning for Trust services. If the person was also under Trust care, the PSIRF response and safeguarding/DHR processes will run alongside each other and be coordinated to avoid duplication.	
Homicide by a person who was under Trust care or discharged within the previous six months	Complete an immediate internal learning review and submit the required information to NHS England. NHS England will decide whether an independent patient safety investigation is required or whether learning should be taken forward locally.	Agree immediate safety actions while NHS England considers the review route. Work with police, safeguarding partners and community safety partnerships where other statutory
Death of patients in custody/prison/probation	Refer to the Prison and Probation Ombudsman or the Independent Office for Police Conduct, as	

National priorities		
	required. Where BSMHFT care was involved, complete an immediate internal learning response, such as a hot debrief, to identify urgent safety actions and support staff. The Trust will contribute to the external review and consider whether any additional proportionate PSIRF response is needed. This should be coordinated with PPO/IOPC processes so learning is shared and duplication is avoided.	reviews are required.
Deaths of people detained under the Mental Health Act, or where the Mental Capacity Act applies, when the death may be linked to problems in care		
Patient safety incidents resulting in death where problems in care are thought more likely than not to have contributed		

Clarifying homicide and domestic homicide responses: PSIRF, safeguarding and Domestic Homicide Review processes may run at the same time, but they have different purposes. A mental health-related homicide will have an immediate internal learning review and will be submitted to NHS England, who will decide whether an independent patient safety investigation is required. A domestic homicide or suspected domestic abuse related death will be managed with the Trust safeguarding team and the relevant Community Safety Partnership or local domestic abuse/DHR coordination process so a Domestic Homicide Review decision can be made. In both situations, immediate learning will be identified, urgent safety actions agreed, statutory reviews supported, people involved compassionately, and PSIRF, safeguarding and statutory review processes coordinated to share learning and avoid duplication.

5.0 Our patient safety incident response plan: local focus

5.1 How we decide the most appropriate response

When a patient safety incident is reported, an early assessment helps identify immediate safety actions, support needs, Duty of Candour, safeguarding and any statutory or external reporting requirements. We consider what is known, the actual or potential harm, national requirements, links to our local priorities, previous similar incidents and the questions or concerns of those affected. This helps us choose the response most likely to provide useful learning and support improvement.

How we decide the response		
Immediate needs	**Learning needed**	**Improvement route**
Safety actions, support, Duty of Candour, safeguarding and external reporting.	Harm, new learning, previous incidents, themes and questions from people affected.	A proportionate response that supports useful learning and safer care.

Our patient safety priorities:

Our patient safety priorities		
Priority	**Approach**	**Improvement route**
Co-morbidity with drug or alcohol use for people in active treatment with BSMHFT. Fragmentation across pathways and transitions, particularly during discharge, leave, transfer, waiting periods or multiple service contacts. Difficulty engaging with services, non-attendance or barriers to accessing care, particularly where this occurs alongside increasing or cumulative risk. Recognising emerging or escalating risk, including repeated crisis, duty or urgent contacts where there is no clear evidence of coordinated review or revised care planning.	Incidents in these priority areas will be triaged to identify the most proportionate learning response. A PSII will be considered where there is significant potential for new system learning, an index case, a cluster, or a national PSII requirement. Other responses may include After Action Review, multidisciplinary review, case note review, thematic review, cluster review or local learning review.	Learning will shape local safety actions and Trust improvement work. This includes strengthening transitions, recognition of cumulative risk, engagement, family and carer involvement, care planning, senior clinical oversight and pathways for people with co-occurring mental health and drug or alcohol needs. Progress will be monitored through operational, clinical governance and improvement forums.

5.2 Choosing the right learning response

Choosing the right learning response	
Where an incident does not meet the criteria for a Patient Safety Incident Investigation or Trust priority, we will choose the most proportionate learning response to improve understanding and support safer care. Decisions will consider harm, potential new learning, previous similar incidents and wider organisational or system themes. Learning will be reviewed alongside other intelligence to identify recurring risks and improvement opportunities.	
Learning response	**Purpose**
Safety huddle or hot debrief	Immediate learning, support and safety actions soon after an incident.
After Action Review	Structured team reflection to understand what went well, what was difficult and what can be improved.
Multidisciplinary review	Understanding care across teams, services or professional groups.
Case note review	Focused review of care, documentation, decision-making and risk formulation.
Thematic or cluster review	Understanding patterns, recurring themes or linked incidents across a service or pathway.
Patient Safety Incident Investigation	A systems-based investigation where national requirements apply or there is significant potential for new system learning.

5.3 Decision-making and oversight

Urgent safety actions, support for those affected, Duty of Candour and safeguarding actions will not wait for panel review. The panel records the rationale for the agreed response, including why a PSII is or is not required. Decisions may be revisited if new information, concerns or themes emerge.

5.4 Health inequalities and inclusion

Health inequalities will be considered in patient safety incident responses. This means thinking about whether access, communication, reasonable adjustments, culture,

disability, ethnicity, deprivation, language, digital exclusion, neurodiversity or other factors affected a person's care or experience. Where inequalities are identified, actions should link to equality, inclusion, service improvement or community engagement work.

5.5 Working with system partners

Where incidents involve more than one organisation, the Trust will work with system partners to agree a coordinated learning response. This may include a shared chronology, joint review, contribution to another organisation's review, or escalation through provider collaborative, Integrated Care Board, safeguarding or place-based governance arrangements.

5.6 Avoiding duplicate reviews

Not every incident will be investigated in the same way. Where another statutory or partner-led review is already taking place, we will avoid duplication while ensuring urgent safety actions and Trust learning are identified and acted on.

5.7 Turning learning into improvement

Learning only improves safety when actions are followed through. All actions from learning responses are recorded on the Trust's patient safety action tracking system and allocated to a named lead with agreed timescales. Progress is overseen through the Trust's patient safety governance arrangements and reported through the Clinical Governance Committee. This gives assurance that actions are implemented, evidence of completion is reviewed and, where possible, the impact of changes is evaluated. Delayed actions or recurring themes are escalated through governance processes to support accountability and sustained improvement.

5.8 Other cause group incidents

Incidents outside the national requirements and local priorities will still be reviewed to identify immediate safety actions, support needs and useful learning. The response will be proportionate to the incident and may include a local review, After Action Review, multidisciplinary review, case note review or thematic review where patterns are emerging.

5.9 Duty of Candour

Being open and honest with people when something has gone wrong is an important part of our response to patient safety incidents. The Trust will continue to meet its statutory

Duty of Candour responsibilities and, where Duty of Candour applies, people affected will receive a timely and honest explanation, an apology, information about what will happen next and appropriate follow-up in line with national requirements.

Duty of Candour is not dependent on a Patient Safety Incident Investigation being undertaken. It applies where the statutory criteria are met, regardless of the learning response selected. Our approach to openness and compassionate engagement extends beyond the statutory process, recognising that service users, families and carers affected by incidents need clear communication, opportunities to ask questions and ongoing involvement as learning develops.

5.10 Engagement and support following an incident

Compassionate engagement is central to how we have implemented PSIRF. We recognise that the way people are treated following a patient safety incident matters. Service users, families, carers and staff should feel listened to, supported and able to ask questions, including when those questions are difficult.

People affected by an incident will be offered early, honest and compassionate communication. We will explain what is known, what remains uncertain and what will happen next, and ask how they would like to be involved. Their questions and concerns will help shape the learning response, rather than involvement taking place only once a review has been completed.

What people can expect from us	
Early contact	Clear, compassionate communication as soon as possible after an incident.
Meaningful involvement	Opportunities to ask questions, share concerns and help shape the learning response.
Ongoing support	A consistent point of contact where appropriate, including support from the Family Liaison Officer role.
Feedback on learning	Sensitive sharing of outcomes, including how learning has informed improvement.

Our approach has increasingly focused on building relationships with people affected by incidents and creating opportunities for meaningful involvement throughout the learning response. The Family Liaison Officer role has expanded to support service users as well

as families and carers following serious patient safety incidents. This provides a consistent point of contact, helps people understand the learning response, identifies the questions they would like us to consider and supports ongoing involvement as learning develops. The role also helps us understand what support service users, families and carers may need and signposts or connects them with appropriate support. Patient Safety Partners may also contribute to learning and improvement, where appropriate. Outcomes will be shared in a clear, sensitive and meaningful way, including how learning has informed improvements.

Compassionate engagement also extends to staff. We recognise that being involved in a patient safety incident can have a significant impact on the people delivering care. Staff can access support through our Post Incident Support Team and post incident support toolkit. Learning responses should also create psychologically safe spaces for reflection and curiosity, recognising that openness is essential to understanding system factors and improving care.

By listening with curiosity, responding with compassion and acting on what people tell us, we aim to strengthen trust, support an open learning culture and ensure that the experiences of people affected by patient safety incidents genuinely influence how care improves.

5.11 Reviewing whether this plan is working

The Trust will keep this plan under regular review through patient safety and clinical governance arrangements. Reviews will include Patient Safety Partners so that lived experience helps shape priorities. Reviews will consider whether responses are proportionate, learning is leading to improvement, actions are being implemented and tested, service users, families and carers affected by incidents feel meaningfully involved, and new or emerging themes require changes to the plan. Formal review will take place within 18 months, or sooner if significant new risks or learning emerge.