Paloma Health

Patient Safety Incident Response Plan

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Contents

1. Introduction

This Patient Safety Incident Response Plan (PSIRF) outlines Paloma Health's approach to responding to patient safety incidents. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred, as well as the needs of those affected.

2. Our services

Paloma Health provides autism assessments for children aged 2-18 in line with our NHS contractual requirements. Paloma has two care pathways:

- Fully remote, where all appointments are online, and the parent or child is seen in their own home
- Hybrid, with parent appointments delivered online, and child observation appointments delivered in one of our in-person clinics in Exeter or Norwich.

Further information about our organisation and services is detailed on the Paloma Health website.

3. Defining our patient safety incident profile

Paloma has identified and agreed on the patient safety issues most pertinent to the organisation and specifically our only service line, children's autism assessments, through the following actions:

Stakeholder engagement:

- Our CEO and Medical Director, along with our Executive Team and Clinical Leads, partnered to define common incidents from their experiences.
- We engaged our Patient Experience Partner group of parents whose children have been through the NHS Children's Assessment Pathways
- Our PSIRF Policy and Plan have been reviewed by our ICB partners and expert advisors from the Independent Healthcare Provider Network

Workforce analysis:

- Paloma's CEO acts as our Incident Response Officer, supported by our Medical Director as required
- Paloma's Clinical Operations Manager is our Learning Response Lead
- Paloma's Senior Safeguarding Officer provides expert input into all patient safety incidents linked to adult and child safeguarding
- All patient-facing staff and their line managers at Paloma receive training on the PSIRF and PSIRP, as well as mandatory training on patient safety, to ensure that patient safety incidents are identified, appropriately reported, and escalated.
- Our Patient Experience Partners, 6 parents whose parents have been through an NHS children's autism assessment service, are engaged as needed, and over the next 18 months, we plan to further embed these partners in our patient safety strategy and planning.

Data sources:

- We reviewed our incident reports since Paloma began delivering patient care in November 2024.

The specific patient safety issues identified from expert opinion are:

- Children on our waiting list who have either clinical or safeguarding risks.

- Children who are assessed by Paloma and potentially receive an incorrect diagnosis

Paloma has not had any patient safety incidents to date, so there are no specific incident learnings to include.

Identified risks are recorded in our organisational Risk Register, with detailed risk assessments and clear mitigation plans.

The Paloma Clinical Governance Committee is responsible for identifying potential risks and reviewing incidents to ensure they are added to the risk Register where required.

4. Our PSIRP

Paloma is committed to continuously improving our service and patient safety. Our Clinical Governance Committee meets quarterly to review themes from incidents and responses, and to ensure they drive a continuous improvement plan.

Our patient safety incident response plan: national requirements

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria	Patient Safety Incident Investigation (PSII)	Our Incident Officer and Medical Director follow our incident response process, and feed these into the quality improvement strategy which is reviewed as part of our quarterly Clinical Governance Committee meetings
Death is thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	PSII	Our Incident Officer and Medical Director follow our incident response process, and feed these into the quality improvement strategy which is reviewed as part of our quarterly Clinical Governance Committee meetings
Incidents meeting the criteria for reporting to the Care Quality Commission (CQC) - i.e. notifiable safety incidents	PSII	Our Incident Officer and Medical Director follow our incident response process, and feed these into the quality improvement strategy which is reviewed as part of our quarterly Clinical Governance Committee meetings

Paloma Health

Our patient safety incident response plan: local focus

Patient safety incident type or issue	Planned response	Anticipated improvement route
An incident which links to the safeguarding of a child or adult	PSII	Our Safeguarding Officer is responsible for partnering with the Incident Officer to complete a PSII and identify appropriate safety actions, which are then fed into pathway and process improvements by our Clinical Governance Committee
An incident which links to clinical risk in a child, e.g. self-harm requiring treatment	PSII	Our Incident Officer is responsible for partnering with the Medical Director to complete a PSII and identify appropriate safety actions, which are then fed into pathway and process improvements by our Clinical Governance Committee
Achieving a good or outstanding rating with the CQC	Clinical Governance Committee pre-planning	Our Committee, led by our Clinical Operations Manager, has developed an Action Plan to ensure we achieve all of the requirements set out by the CQC.
Embedded Patient Experience Partners (PEPs) into our pathway and patient safety improvement work	Active engagement by our Product Team	Our Product Team will build our engagement strategy with PEPs to ensure they are embedded in pathway and patient safety improvement work