Psicon

Our Patient Safety Incident **Response Plan**

Contents

Foreword from **Managing Director** at **Psicon**

At Psicon, ensuring that safe, compassionate, person-centred care is consistently delivered is at the core of what we do.

We recognise that for many of our clients, accessing our services is a significant moment - often following long waits or complex experiences. With that comes a clear responsibility to respond to risks with care, rigour, and accountability.

The national Patient Safety Incident Response Framework (PSIRF) is a whole system change to how we think and respond to Patient Safety Incidents. It is an exciting opportunity that represents a chance to evolve our approach to safety culture.

PSIRF encourages us to move away from mandated investigations and precise timescales to instead supporting how to prevent recurrent incidents.

The foundation of PSIRF is that of a just culture, where psychological safety is crucial in ensuring an environment which empowers staff to highlight where things could be improved, knowing that the focus will be one of learning and improving and not on retribution or blame.

This Patient Safety Incident Response Plan (PSIRP) sets out how we at Psicon intend to respond to patient safety incidents. We pride ourselves in being flexible and holistic in our approach; enabling us to understand the bespoke needs of those affected by patient safety incidents.

We recognise that this is the start of our journey, that there is a lot to do and our plan will continue to evolve and mature over time. We want to not only meet the requirements, but to surpass them. Embedding this approach within our Clinical Governance framework reflects our organisation's values and commitment to patient safety, continual learning whilst making meaningful sustainable improvements to our services.

Dr Dan Simmonds
Managing Director
Psicon

Purpose, Scope and Aims

Purpose

This Patient Safety Incident Response Plan (PSIRP) supports the requirement of the Patient Safety Incident Response Framework (PSRIF) and outlines how Psicon intends to respond to and learn from adverse events involving patients reported by staff, employees, patients and families. The sole purpose of which, is that of learning and improving patient safety. This includes ensuring that learning is systematically identified, tracked, and embedded through governance processes, audit activity and service improvement initiatives.

Our PSIRP will continuously evolve as we learn from our experiences within PSIRF. We will continue to remain flexible and consider the specific circumstances surrounding patient safety incidents (PSIs) along with the bespoke needs of those affected by them.

Scope

It is important to note that whilst we provide contracted support to the NHS, PSIRF will apply to any patient treated or assessed by Psicon. In addition, whilst the NHS PSIRF approach does not include private services, we have made the decision to apply the PSIRF principles to our private patients, therefore ensuring consistency for all PSIs and to provide a larger pool of patient safety information from which we can learn and improve. This ensures a consistent approach to incident response, learning and improvement across all services, regardless of funding pathway.

All of our responses to patient safety incidents, will follow the system-based approach, thus recognising that patient safety is emergent, it can be affected by the many interactions between components and not from one single factor.

This Plan is underpinned by our Quality Assurance Framework; policies on adverse event reporting, InPhase (our quality management system) and our PSIRF policy.

Aims and Objectives

There are four key aims of the PSIRF approach which align to the our core values:

Trust

PSIRF promotes open, compassionate engagement with patients, families, and staff following patient safety incidents. By being transparent, listening carefully, and involving those affected, we build trust and confidence in how incidents are responded to and learned from.

Integrity

Through system-based, fair, and objective approaches to learning, PSIRF ensures incidents are explored honestly and without blame. This reflects integrity by focusing on understanding what happened and why, rather than attributing fault, and by using findings ethically to improve care.

Commitment

PSIRF supports considered and proportionate responses to incidents, demonstrating a strong commitment to continuous learning and improvement. By tailoring responses appropriately, we show dedication to improving safety, quality, and outcomes for patients and staff.

Kindness

Kindness and compassionate engagement is central to PSIRF, particularly in how we support patients, families, and staff affected by incidents. A supportive oversight approach ensures psychological safety, promotes learning, and reflects kindness in both leadership and practice.

The primary aim of our PSIRP is to create a compassionate just culture which provides the psychological safety necessary for any staff member or patient to speak up about any concerns they may gave in relation to patient safety incidents.

This will enable us to move away from a reactive approach to PSIs to one that reduces the likelihood of their occurrence and where possible avoids them.

A further aim is to involve patients and families / carers in improving patient safety by engaging meaningfully with them and actively seeking their feedback on perceptions of the safety of care delivered as well as involving them within their own incident investigations and associated learning.

By engaging Patient Safety Partners (PSPs) we aim to improve the systems in which care is delivered as well as the experience of those receiving it.

Ensuring that people have access to high quality ADHD/Autism assessments and treatment is Psicon's overall purpose. Our Quality assurance Framework, as outlined in figure 1, is key to enabling us to achieve this purpose.

Figure 1: Quality Assurance Framework

Progress against these aims is monitored through incident data, thematic reviews, audit findings and governance reporting to ensure that learning results in demonstrable improvement.

Developing our PSIRP

In order to create our PSIRP we have undertaken a variety of steps, these include:

- Examining our patient safety incident records
- Describing the safety issues found in the patient safety incident (PSI) records
- Identifying improvement plans
- Agreeing the types of proportionate responses that can be used when investigating a patient safety incident

Psicon **Structure** and **Services**

Psicon's Structure

Psicon has been providing wellbeing services, ADHD and autism assessment and treatment since 1998. Focusing on high quality care that is delivered by experts in the field.

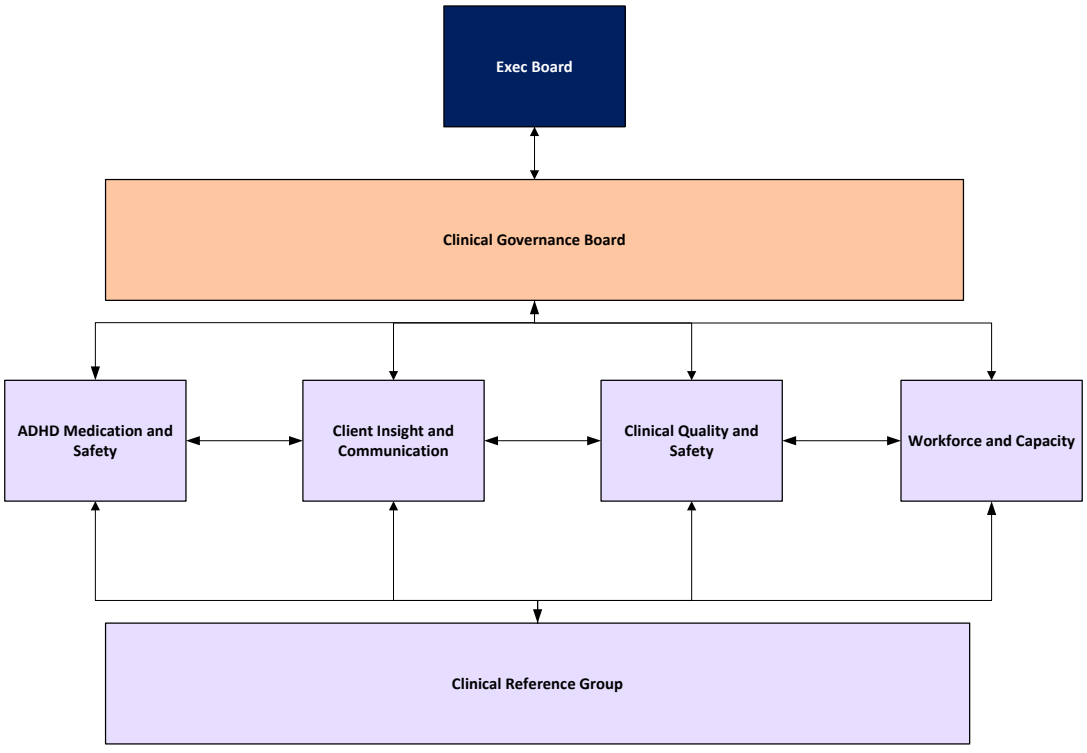
We have since grown in size and reach, both in the UK and internationally. We are now one of the largest providers of neurodevelopmental services in the country and our multidisciplinary team is now over 300 strong. In 2023 Psicon joined the Onebright family, the UKs leading outpatient private mental health service.

Despite the fact that PSIRF will currently only apply to NHS services, we have made the decision to apply PSIRF to all of our patients, regardless of funding source. We feel this will ensure consistency and continuity in the management of and learning from PSIs.

Quality and Safety Governance

To achieve our PSIRF aims and objectives, we require a robust Clinical governance approach that builds on our Quality Assurance Framework.

Figure 2: Clinical governance framework



Our Patient Safety Incident response is overseen by:

- Clinical Governance (CG) Subgroups: Review risk themes, PSIRF findings, and learning logs.
- Clinical Governance Board: Triangulates subgroup outputs, approves system-wide actions, and ensures whole-system learning across adult and Children and young People Services.
- Director of Nursing: Provides professional oversight for nursing-led risk reviews.
- Head of Quality: Coordinates PSIRF reviews, maintains incident registers, tracks actions.
- Executive Team: Receives escalations for high-severity or systemic risks.
- Experts by Experience (EBE): representatives from our EBE to provide lived in expert experience to provide independent expertise and advice.

This structure ensures that patient safety incidents are reviewed at the appropriate level, with clear escalation of risks, themes and learning, and with oversight provided through the Clinical Governance Board.

Our governance system ensures incident response is integrated with operational and clinical quality processes. As such PSIRF has required us to think organisationally how we can gain the most benefits from organisational learning whilst retaining oversight of PSIs across differing services.

On a daily basis Quality Leads of local services review any PSIs recorded on the previous days. Any requiring learning responses are highlighted to the departments manager, along with the quality and safety team. These are discussed at the weekly incident open door meetings. Actions and learning identified are tracked through governance processes to ensure completion and effectiveness.

A new forum has been created during the implementation of PSIRF: the Psicon Safety Group. This monthly meeting looks at emerging themes of PSIs of specific concern which then become a focus for patient safety improvement activities.

Outputs from the Psicon Safety Group are fed into the clinical governance framework and escalated as required to the clinical governance board. This enables triangulation of incident data with audit findings, client feedback and operational performance data to support system-wide learning.

Psicon followed the steps as outlined by the NHSE PSIRF Preparation guide (august 2022). Table 1 details the implementation team which was established.

Roles and responsibilities

Role	Responsibility	Psicon Equivalent
Senior Responsible Officer	Chair and Lead the PSIRF Implementation	Managing Director
Deputy Responsible Officer	Support the above	Head of Quality
Patient Safety Lead	Expertise in: • Patient Safety • Patient Safety Incident Response • Human Factors	QI & A Manager
Quality Improvement Lead	Thematic Reviews to shape PSIRP	Head of Quality
Medical Assurance Lead	Consultant engagement	Chief Medical Assocaite
Clinical Safety Specialist	Consultant Engagement / Patient safety expertise	Head of Quality
Risk Management Lead	Expert in risk management	QI & A Manager
Clinical and Quality Governance Lead	Develop the PSIRP and roll out: • PSIRF policy • Identify Learning response	Head of Quality
Operations Lead	Recognise and communicate business impact to exec board	Director of Operations
Academy Lead	Training for: • Learning response leads • Engagement leads • Those in PSIRF oversight roles • Recruit patient safety partners	Learning and Development Manager
Customer Experience	Complaint management – thematic reviews Patient and family involvement plan/standard	Head of Quality / QI & A Manager
Legal Team Lead	Ensure learning responses meet legal requirements	Head of Legal
Head of Safety culture	Compassionate engagement Just culture	Head of People and Performance
Internal and External comms Leads	Stakeholder list and engagement plan Identify key messages and methodology for sharing	QI &A Manager / Head of Marketing
Data Analysist	Thematic reviews Ongoing monitoring and triangulation of data	Head of Quality QI&A Manager
Human Resources	Recruitment of PSPS Training regarding engagement with employees involved in incidents	Head of People and Performance Learning and Development Manager

*Table 1

Psicon Services

Psicon is a national provider of neurodevelopmental assessment, ADHD prescribing, and therapeutic services for children, young people, and adults. Our pathways include NHS Right to Choose assessments, private and PMI-funded care, and digital ADHD medication management.

We are a clinically led, values-driven organisation, working to ensure that all clients experience safe, effective, person-centred care, underpinned by robust governance and a culture of learning. Much of our clinical activity involves one-off or short-term diagnostic assessments, alongside ongoing ADHD prescribing, therapeutic interventions, and wellbeing support.

Our clients often present with complex needs, including emotional distress, safeguarding risks, or mental health difficulties that may not have been previously identified or supported. Many have experienced long waits for diagnosis or care. We recognise that our work can be a critical point of intervention, where robust systems, skilled clinicians, and clear risk management make a real difference.

Our organisational model includes:

- Large-scale diagnostic assessment pathways (including NHS-funded, private, and private medical insurance (PMI) streams)
- A national ADHD prescribing service with remote and digital delivery
- A multi-disciplinary team including paediatricians, psychiatrists, clinical psychologists, speech and language therapists, occupational therapists, and nurses
- A fully operational Clinical Governance system with regular Boards and Subgroups providing clear reporting, learning, and escalation pathways

Given this context, our approach to patient safety requires:

- Proactive identification and management of risk
- Clear, system-focused incident response
- Transparent, proportionate learning processes
- Ongoing review and improvement embedded within governance structures

Implementation

Patient Safety Culture

We are proud and committed in ensuring that staff work within an environment where they feel respected, valued and supported. We want to ensure that staff understand how their work contributes to and is integral to ensuring that patient safety remains a top priority.

We recognise that by creating an environment which provides psychological safety – this will enable and empower our staff to speak out when they are concerned about anything that may impact on the safety and wellbeing of our patients.

This culture is supported through regular supervision, training, and governance forums that encourage reflection, shared learning and continuous improvement.

What is a just culture

The Nursing and Midwifery Council (2021) describes Just Culture as 'One that balances fairness, learning and accountability'.

The success of Psicon's PSIRP will rely on a Just Culture where staff, patients, families and our stakeholders expect to be:

- Treated with kindness and compassion.
- Told the truth when things go wrong and why this has happened.
- Included in the investigation and asked what they would like to find out during investigations to incidents and contribute to any actions which may help to improve safety.
- Have access to and be able to read the full written responses to incidents.

Developing a Just Culture

Psicon's Head of People and Performance fulfils the role of the Head of Culture and we have developed a new Psicon Safety Group who's primary function is to ensure that all staff feel able to raise their concerns about patient safety. We have a variety of ways that this can be done to ensure that staff have the support required to do this, this includes:

- Monthly open-door sessions with members of the Senior Leadership Team
- Weekly Incident open door sessions
- Monthly Psicon safety group
- Clinical Governance Framework
- Nominated Freedom to speak up champions
- Our bi-annual engagement survey

Psicon ensures that all staff throughout the organisation receive training in understanding what a Just Culture is and how they can support the wellbeing and safety of our patients. This now forms part of our staff induction, therefore setting expectations for all new staff members.

Formal training for all staff within Psicon includes members of the Board and the Senior Leadership team. This ensure that everyone understands the impact of just culture and psychological safety on the staff they are responsible for.

Leaders at all levels are responsible for modelling and reinforcing a just culture, ensuring that staff feel supported to report incidents and contribute to learning without fear of blame.

What is psychological safety

Psychological safety can de defined as "the belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns or mistakes, and that the team is safe for interpersonal risk taking" (psychsafety.co.uk).

Psicon recognises that this is essential for all healthcare providers and professionals to enable them to feel comfortable raising and sharing their concerns, fears or issues especially when they may impact on the quality of care that we provide.

Patient Safety Partners (PSPs)

Patient Safety Partners are a new concept for Psicon, which we recognise will further complement and enhance our Quality Assurance and Clinical Governance Framework. At present the role of PSPs within Psicon will be fulfilled by existing staff members and our EBEs. We anticipate the role of our PSPs will evolve over time and our intention is that as our business continues to grow we will recruit additional PSPs and implement these as required. This will be reviewed annually as part of our Psicon Safety Group and Clinical Governance Framework.

PSPs will support us in a variety of ways including:

- Participating in interview to support staff, families and patients
- Help to understand equality barriers so that patient safety is fair and equal to all
- Support families, carers and patients to be involved in their own safety incidents
- Support families, carers and patients to escalate concerns or problems
- Understand how services are run and make them safer

Feedback from PSPs is incorporated into learning responses and service improvement activity where appropriate.

Engaging and involving Patients, Families and Staff

Thematic analysis of feedback from patients, families and care givers provides insight into their experience of service delivery, in particular their perception of feeling safe whilst receiving care from our services.

Involving patients, families and staff is a fundamental aspect of the PSIRF approach due to:

- Being the best way to learn from incidents that they are involved in
- Encouraging them as partners in their own safety
- Recognising the vital role that they play in improving the safety of care.

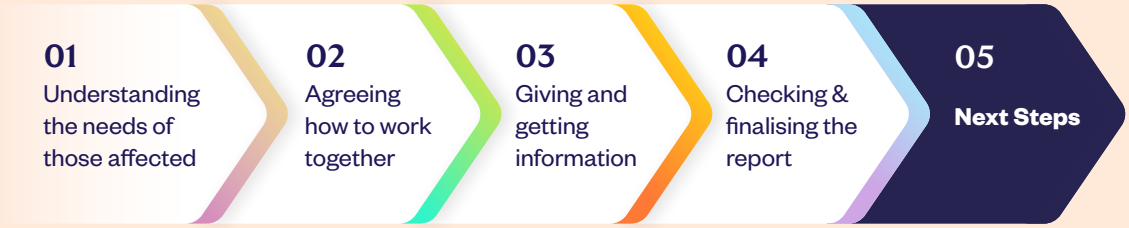
We understand that learning and improving following a patient safety incident can only be achieved if supportive systems and processes are in place.

Our new approach to managing, investigating and responding to patient safety incidents prioritise compassionate engagement and involvement of those affected by patient safety incidents. This includes understanding and responding to any questions or concerns they may have in relation to the incident.

Being open, honest and transparent, are central to the PSIRF approach and in order to support this, a kind and compassionate approach is essential when investigating patient safety incidents. This includes fulfilling Duty of Candour requirements, ensuring that patients and families are informed, supported and involved throughout the incident response process.

We have adopted and advocate the use of the Learn Together Guides to provide support and information to staff, families and carers during a patient safety incident investigation.

When engaging with patients and families we recognise that there is a five-step process including:



We understand that being involved in and reflecting on patient safety incidents can be upsetting, as such Psychological first aid will be made available to all staff affected by an incident.

Being open and transparent reassures clients, families, colleagues, and referrers that an incident has been recognised, their concerns acknowledged, and action taken. This approach also helps prevent incidents escalating into formal complaints or legal disputes, which can be distressing for all involved. Psicon is committed to meeting its Duty of Candour obligations

Addressing Health Inequalities

Psicon works across a variety of different co-designed services that meet the local needs of the populations. When a patient safety incident occurs, staff managing those sites will ensure that they undertake a full investigation, during which they will ascertain if there is anything which may affect the patients or the families ability to be fully involved in any learning responses. **These may include a persons:**

- Age
- Disability
- Gender Reassignment
- Marriage and Civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sexual orientation

These are known as ‘protected characteristics’ and Psicon will work to ensure that all individuals are offered the opportunity to be involved in any learning responses in an appropriate way for their needs.

As a provider of referrals, assessments and medication to individuals with ADHD and Autism, Psicon is aware that people with a learning disability and autistic people may often have poorer physical and mental health than others and may face barriers to accessing health and care to them living well.

Patient Safety Incident Profile

Given trends in historical data, Psicon has chosen to focus on the following local priorities with the view to improve outcomes:

01 Care Pathways

One of the highest reported incident rates within the business. This includes delays to treatment due to care pathways being moved incorrectly, late, or not at all.

Aims

- To reduce incidents by 10%
- Increase knowledge and skills of workforce around the requirement of care pathways

Q4 2026

02 Data Breaches

A high number of incidents relating to information being sent to the wrong recipient, this includes emails being sent to the wrong recipient, reports being shared without consent or to the wrong email address.

Aims

- To reduce incidents by 10%
- To improve company wide awareness of data protection.
- Appointment of Information Governance Lead.

Q4 2026

03 Booking Optimisation

A number of incidents that related to appointments that were either delayed, cancelled or missed due to incorrect booking information being shared, e.g. the wrong route: teams vs in person, incorrect location,

Aims

- To reduce incidents by 10%
- Ensure more robust quality checks of booking appointments.
- Support staff training with use of IT systems

Q4 2026

04 Medication Management

As our regulated activity, there has been a number of incidents relating to prescription errors, delays in medication provision and prescriptions being sent to incorrect locations

Aims

- To reduce incidents by 10%
- Ensure robust quality checks of all prescriptions
- Ensure review of medication operations to ensure appropriateness of workforce capacity.

Q3 2026

Progress against improvement plans is monitored through governance structures and reviewed regularly to ensure that actions lead to measurable reductions in risk and improvement in outcomes.

Patient Safety Improvement **Profile**

Improvement initiatives are identified through data analysis including both quantitative and qualitative approaches.

Monitoring and tracking of this data will include regular reviews from the Senior Leadership Team and the Psicon Safety Groups.

Regular updates to any relevant policies and procedures based on this analysis will be undertaken and learning shared for learning and continuous improvement.

Governance and Oversight

Reporting to internal and external stakeholders, senior management and regulatory bodies is a continuous process which is fully embedded into our reporting structures.

Our newly created Psicon Safety Group is responsible for overseeing the implementation, curation and ongoing review of our PSIRF and PSIRP.

Reviewing our PSIRF Policy and Plan

We consider our PSIRP and PSIRF to be a living documents, whilst formally they will be reviewed on an annual basis to ensure our focus remains up to date, we also intend to ensure that they will be reviewed and amended in real time to incorporate new learnings and changes to regulations.

We will continue to publish any updates to our PSIRP on our website, replacing any older versions.

Patient safety Incident Response Plan (PSIRP)

PSIRF allows more flexibility in the methods which can be used in responding to Patient Safety Incidents, depending on the nature, severity and frequency of the incident occurring.

There are certain national requirements that are set by Government bodies for specific types of patient safety incidents that Psicon must either investigate or refer to another body. These include:

- Incidents previously categorised as Never Events
- Incidents meeting learning from patient deaths(LeDeR) criteria
- Death of a child
- Death of a person with Learning Disabilities
- Safeguarding

In addition, PSIRF enables us the ability to define specific patient safety incidents to investigate in greater depth even if they have caused no or very little harm.

This enables Psicon to see the greatest improvements to patient safety concerns by focusing and understanding those things which happen more often.

Psicon does not set a target to minimise incident reporting. Instead, we monitor incident trends, harm severity, and learning outcomes. An incident reporting rate of approximately 8–25 per 1,000 client contacts is considered consistent with an open and mature safety culture in community mental health services.

In many cases risk is highlighted not by the severity of the outcome but by the frequency with which incidents or potential incidents occur. Therefore, we will review trends in data over a rolling 6-month period utilising the following traffic light system as a guide:

Red	Amber	Green
Any increase in serious harm or regulatory-risk events Death of a person with learning difficulties Death of a person as a direct result of Psicon care delivery	Sudden spike, new theme, or >25 without explanation	8–25 / 1,000, stable trend, strong learning actions

All incidents will be responded to using our internal Incident Review Process.

Responding to incidents

Regardless of the proportionate response method chosen for a specific incident, the aims are the same:

To:

- Respond to concerns raised by any patient, their family of staff member
- Understand what contributed to the incident happening in the first place
- Identify areas for improvement
- Improve safety for future patients
- Reduce the risk of incident recurrence.

The type of response is determined based on the severity, frequency and learning potential of the incident, in line with PSIRF guidance and organisational priorities.

Compassionate engagement and transparent communication is undertaken with patients, families and staff members affected by the incidents. Ongoing support will be provided to those involved using the NHS debrief tool.

Compassionately engaging with each of those involved using the just culture ethos will enable us to obtain deeper understandings of what has happened and what they think may have contributed to the patient safety incident. On completion of the investigation a detailed report will be shared with all of those involved in the incident and investigation.

Incident reporting

As part of our incident reporting process, we have clear procedures for reporting incidents. This is outlined in Appendix A: Psicon Decision Tool.

We utilise an electronic quality management system (Inphase) to log and investigate all adverse events including incidents, complaints and concerns.

All new starters joining our organisation will be provided with training on this system which is tailored to their role ensuring that they are fully supported to log incidents in a timely manner. All incidents must be reported as soon as practicable to ensure timely review, response and learning.

Weekly, all incidents within the company are reviewed and ratified, with themes, investigations and lessons learned discussed.

Monthly all incidents are reviewed using a thematic approach and reported to the relevant sub-group committee for dissemination to the Clinical Governance Board as appropriate.

Learning from incidents informs:

- Updates to clinical documentation standards.
- Associate clinician induction and training content.
- Supervision focus areas (e.g. documentation, risk formulation).
- Audit cycles (e.g. report writing, safeguarding documentation).
- Policy review and service development.
- Improvements to Service Health Checks and quality dashboards.

Our Clinical Governance Board ensures themes identified through PSIRF are triangulated with audit findings, client feedback, and wider service intelligence

We also:

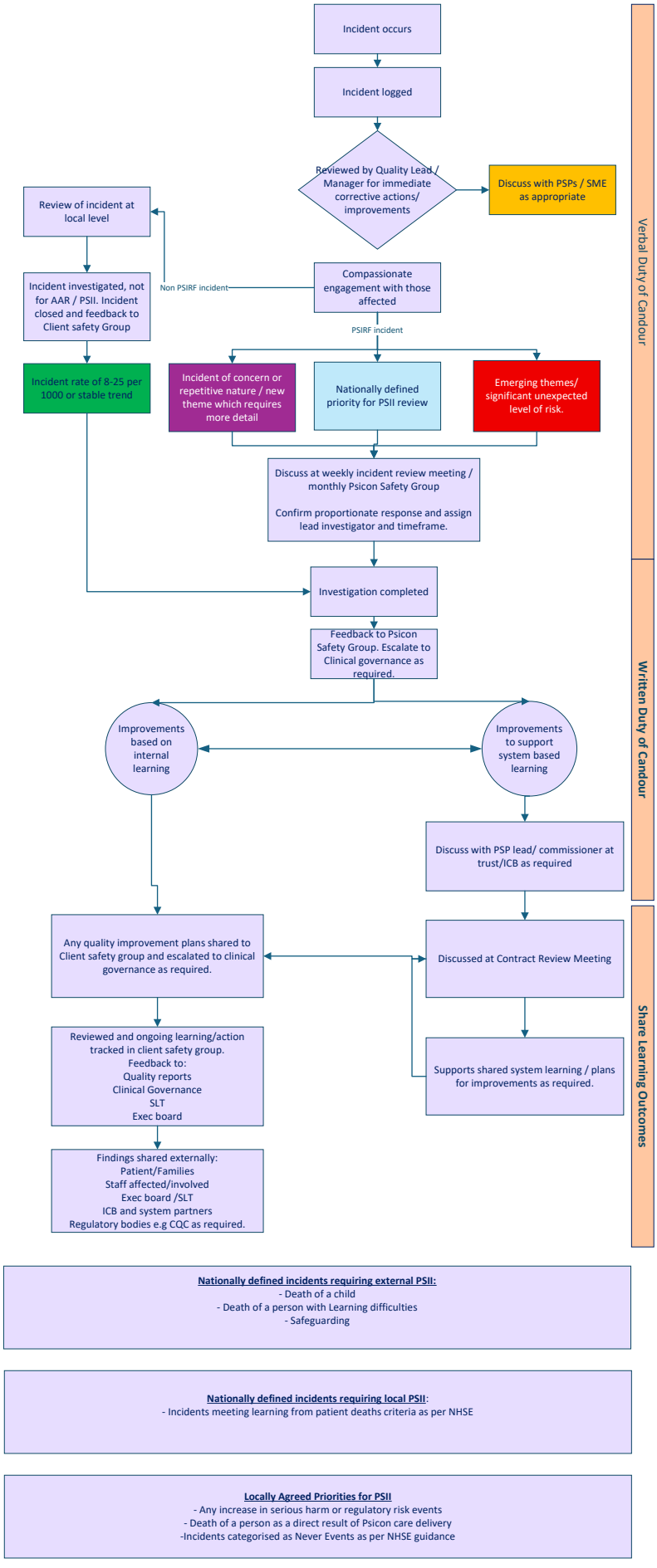
- Share aggregated learning themes and service improvements with clients, staff relevant Integrated Care Boards (ICBs) and commissioning bodies through internal updates, service newsletters, and updated resources.
- Include PSIRF learning outcomes within ongoing governance training and induction programmes.

We feel that our robust Quality Assurance Framework enables us to review incidents using our internal process to address action plans and therefore reduce the risk of recurrent incidents.

The effectiveness of learning actions is reviewed through governance processes to ensure that improvements are embedded and sustained over time.

This PSIRP will continue to evolve as Psicon's services grow and mature, with ongoing review to ensure alignment with regulatory requirements, organisational priorities and emerging learning.

Appendix A: Psicon Decision Tool



Nationally defined incidents requiring external PSII:
- Death of a child
- Death of a person with Learning difficulties
- Safeguarding

Nationally defined incidents requiring local PSII:
- Incidents meeting learning from patient deaths criteria as per NHSE

Locally Agreed Priorities for PSII
- Any increase in serious harm or regulatory risk events
- Death of a person as a direct result of Psicon care delivery
-Incidents categorised as Never Events as per NHSE guidance

References

This PSIRF plan is underpinned by NHS England's national policy and associated guidance documents. It reflects best practice in responding proportionately to patient safety incidents and is designed to ensure compassionate engagement, systemic learning, and continuous improvement across the organisation.

The plan is aligned with the following key documents:

- Patient Safety Incident Response Framework (PSIRF), Version 1, 2022
- Engaging and Involving Patients, Families and Staff Following a Patient Safety Incident –

Supporting Guidance

- Guide to Responding Proportionately to Patient Safety Incidents
- PSIRF Preparation Guide
- A Just Culture Guide – NHS England

How to **contact us**

Telephone

If you wish to speak to us directly about your concerns or complaint, you can do so by contacting us on **01227 379099.** Our telephone lines are open Monday to Friday 9am – 5pm.

Email

If you would prefer to contact us about your concerns or complaint via email, you can do so by contacting us at **feedback@Psicon.co.uk**

Our Client Relations service is open Monday to Friday 9am to 5pm and will aim to acknowledge or respond to emails received within 2 working days.

Website

Alternatively, you can complete our short online form via our website, visit **www.psicon.co.uk/contact**