East of England Ambulance Service NHS Trust

Management of Incidents Policy

Document Reference	POL015
Document Status	Approved
Version:	V9.0

DOCUMENT CHANGE HISTORY		
Initiated by	**Date**	**Author (s)**
Serious Incident Panel	June 2009	Risk manager
Version	**Date**	**Comments (i.e. viewed, or reviewed, amended approved by person or committee)**
V2.0	September 2009	Approved at Trust Board
V2.1	March 2011	Reviewed by Implementation Manager and Claims and Litigation Manager for NHSLA compliance
V2.1	July 2011	Approved by Risk Management Group

V3.0	August 2011	Approved by Executive Management Team
V3.1	January 2015	Risk Manager
V3.1	February 2015	Approved by Clinical Quality and Safety Group
V4.0	June 2015	Approved by ELB
V5.0	February 2016	Minor amendments approved by ELB
V5.1	June 2017	Amended and reviewed by Clinical Quality and Safety Group
V6.0	September 2017	Approval at SLB and ELB
V7.0	March 2019	Approval by MAG
V7.1	February 2020	
V8.0	March 2020	Approval by CRG
V8.1	Oct 2021	Amended to reflect current group and role titles.
V9.0	October 2021	Approved by CRG

Document Reference	[e.g. NHSLA – Relevant to standard x …] Directorate: [name of owning Directorate]
Recommended at Date	
Approved at Date	Compliance and Risk Group 15 October 2021
Valid Until Date	March 2024
Equality Analysis	October 2019
Linked procedural documents	Duty of Candour Policy Serious Incident Policy Investigations Guidance

	Learning from Deaths Policy Learning from Deaths SOP
Dissemination requirements	To all staff via the intranet
Part of Trust's publication scheme	Yes

The East of England Ambulance Service NHS Trust has made every effort to ensure this policy does not have the effect of unlawful discrimination on the grounds of the protected characteristics of: age, disability, gender reassignment, race, religion/belief, gender, sexual orientation, marriage/civil partnership, pregnancy/maternity. The Trust will not tolerate unfair discrimination on the basis of spent criminal convictions, Trade Union membership or non-membership. In addition, the Trust will have due regard to advancing equality of opportunity between people from different groups and foster good relations between people from different groups. This policy applies to all individuals working at all levels and grades for the Trust, including senior managers, officers, directors, non-executive directors, employees (whether permanent, fixed-term or temporary), consultants, governors, contractors, trainees, seconded staff, homeworkers, casual workers and agency staff, volunteers, interns, agents, sponsors, or any other person associated with the Trust.

All Trust policies can be provided in alternative formats.

Contents

1. Introduction

It is recognised that within a healthcare organisation, incidents and near misses can and do occur. The recognition and reporting of incidents (including near misses) is vital to the way in which the Trust can respond to issues and avoid repetition of incidents.

Through effective incident reporting, investigation and review, the East of England Ambulance Service NHS Trust aims to learn, evolve and develop processes, procedures and strategies, in order to reduce the level of risk within the organisation.

The aim of this policy is to encourage incident reporting, ensure robust investigations take place, and learn from incidents and near misses, as part of the Trust's safety culture. Adherence to the policy will assist to maintain a high standard of care to patients, as well as to reduce the risk of loss, damage, or injury to patients, staff and others.

2. Purpose

The purpose of this policy is to make clear the incident reporting and investigation process, from incident recognition through to completion of the actions and closure.

If the policy is implemented successfully, the result will be:

- Continuous reduction in levels of harm.
- The provision of a safe environment for staff, patients, visitors and contractors.
- All incidents and near misses reported and investigated in a timely manner and appropriate learning and actions taken as a result.
- To ensure that the Trust complies with current legislation.

Successful implementation of this policy has the overarching aim of reducing patient harm and improving safety for patients, staff, and other key stakeholders.

3. Duties

3.1 The Trust Board

The Trust Board will receive information on incidents via the Quality Report. This is in order to seek assurance that internal controls are in place and are operating effectively in relation to incident management and safety improvement. To gain assurance from the QGC in relation to safety and learning of lessons.

3.2 Quality Governance Committee (QGC)

The Committee is directly accountable to the Board and seeks to provide assurance relating to systems and procedures concerning patient safety. The Committee will receive reports relating to incident management and issues highlighted through investigations in order to provide assurance to the Board, or to raise concerns. Receiving specific data as identified in their Terms of Reference in relation to incidents and serious incidents, trends and themes.

3.3 Compliance and Risk Group (CRG)

The group receives reports from groups including the PSG; it reports to the QGC. Trends and Themes related to safety are escalated to the group. In turn the group escalates concerns to the QGC.

3.4 Patient Safety Group (PSG))

The AMG is accountable to the Executive Leadership Team and has decision-making powers devolved from the Board. It escalates concerns to the CRG. Its purpose is to promote the delivery of safe, effective patient care outcomes and ensure patient and carers' views are actively sought, considered and acted upon and to ensure that appropriate mechanisms are in place to deliver high quality care. The PSG will receive reports on incidents including trends, themes, issues to note, and lessons learned where appropriate. Monitoring the details of incidents reported and lessons learned.

3.5 Serious Incident Panel

To determine the incidents that will be managed under the Serious Incident Policy, as an 'AMBI' or as a locally reviewed incident. To review and agree final SI and serious RIDDOR review reports.

3.6 Chief Executive Officer

The Chief Executive, as accountable officer, has overall responsibility on behalf of the Trust Board for risk management, including the management of incidents.

3.7 Director of Nursing, Clinical Quality and Improvement

The Director of Nursing Clinical Quality and Improvement is responsible for overseeing the arrangements for clinical governance. This will provide assurance of the quality of clinical care and patient safety.

The director is the designated Board member responsible for compliance with the incident reporting procedures on behalf of the Board and Chief Executive.

3.8 Patient Safety Lead, Health Safety and Security Lead and the Safety Team

The Safety Leads are responsible for leading the safety team to monitor incidents and near misses reported, and for escalating potential serious incidents to the SI Panel (see Serious Incident Policy).

The safety team acts to provide a quality assurance mechanism in relation to investigations undertaken. They are also responsible for identifying trends and themes and reporting these to the appropriate managers and groups/committees for action. The Patient Safety Specialists and Health Safety and Security Specialist undertake a review of incidents reported on week days, to determine harm. Where a report is considered to meet Serious Incident (SI) criteria the incident follows the SI Policy. Where and incident requires reporting under the RIDDOR process this policy is followed.

The Safety Leads and Safety Specialists act as advisors to managers when assistance or support is required in the management of

incidents. The relevant Safety Lead is the data owner for all incidents held on the Datix system; will advise on changes to be made to the incidents module.

3.9 Data Protection Officer

The Data Protection Officer (DPO) is a statutory role for all public bodies. They are required to monitor compliance to data protection legislation and compliance with data protection policies. This includes managing internal data protection activities, of which incident reporting is a crucial part. They also provide the link between the organisation and the Information Commissioners Office (ICO) to ensure that there is effective cooperation and cohesion.

3.10 Heads of Departments and General Managers

Heads of departments and general managers are responsible for the provision of care, or portfolio of work, within their allocated designation. They are responsible for ensuring that an investigation into any incident is conducted in a timely manner and to a high standard, in order to ensure that actions are taken to prevent a recurrence.

The ownership of an incident or near miss sits with the head of department, general manager, or relevant equivalent. These managers are responsible for overseeing the investigation process and to provide guidance and support to any manager they may have delegated the investigation to.

The head of department, general manager, or equivalent, in the area in which the incident occurred is responsible for assigning an appropriate investigating officer and ensuring sufficient time for the investigation is allocated. They are responsible for ensuring that the investigation follows due process and that the conclusions drawn are sound and accurate. They are also responsible for ensuring learning is disseminated and shared.

The head of department or general manager is also responsible for implementing Duty of Candour discussions with patients and their families, supporting the investigating officer.

3.11 Investigating officer (IO)

The investigating officer is responsible for ensuring that the investigation is in conjunction with this policy and the Investigations Guidance document, and that the process is undertaken efficiently and effectively using root cause analysis methodology when required and is proportionate to the incident. The IO must produce a report through the completion of the 'investigate this incident' section of the incident record on Datix, which addresses every area of the incident, identifying any areas where remedial action may be taken.

The investigation will use the roundtable review process for investigation of AMBI incidents. Throughout the investigation, the IO will maintain regular contact and provide feedback to staff involved in the incident and to ensure appropriate support is made available where appropriate. The investigator will look to identify good practice as well as opportunities for learning.

Where appropriate, the IO will make and maintain contact with the patient/family to ensure a record of any meeting(s) or information shared is documented and enclosed with the final report (as per Duty of Candour policy).

3.12 All staff

All staff employed by EEAST share the responsibility of reporting incidents and near miss. Staff will be empowered to report events or occurrences which they feel is an incident, some examples of which can be found at Appendix 1. Staff will report such concerns via the Datix system as soon as possible, ideally within 24 hours of the incident occurring. If staff are concerned in relation to a possible serious incident, this should also be identified to the manager on duty on that shift, or via the ambulance operations centre. Supporting documentation must be passed on without delay.

When a member of staff requires to report an incident whilst on duty, the Patient and Vehicle Support Hub shall be contacted; adequate out of service time shall be granted to complete a Datix report. If reporting an incident whilst on duty, the member of staff shall make every effort to report the incident via the Trust's Single

Point of Contact (SPOC) phone number, as this can often be more convenient that using a Trust computer.

Staff involved in an incident or near miss are required to fully participate in an investigation openly and honestly, in order to assist with establishing the facts and the reasons for the incident, and to identify ways in which lessons can be learned to avoid recurrence.

3.13 Trust specialists

Specialist staff such as safeguarding, infections prevention and control, information governance and medicines management are responsible for monitoring issues arising within their specialist field. They are not responsible for routinely conducting incident investigations. However, they should make themselves available to provide advice and support to managers and investigators where there are specialist considerations to take.

4. Definitions

Adverse Incident – An adverse incident can be described as anything which occurs away from the intended course of action, which may or may not have resulted in harm occurring.

Some examples of incidents which should be reported on Datix are as follows:

- A patient becoming physically or verbally aggressive towards a crew.
- Patient given the wrong dose of a medication or via the incorrect route.
- Staff member injures themselves whilst undertaking a manual handling procedure.
- Confidential staff or patient information misplaced.
- Equipment malfunctions during a patient care episode.

This is not an exhaustive list. A more detailed list (but still not exhaustive) can be found at Appendix 1.

AMBI

An incident that does not meet the national criteria to be reported as an SI, that does present an opportunity for organisational learning by detailed examination. Using a roundtable review process, identifying good practice as well as missed opportunities and lessons to be learned.

Near Miss - An incident which has the potential to cause harm but careful management has prevented the incident. For example, a slippery floor where no signs have been laid out but resolved prior to a slip, or a delayed ambulance attendance where the patient does not come to harm.

RIDDOR is the law that requires employers, and other people who are in control of work premises, to report and keep records of:

- work-related deaths
- serious injuries
- cases of diagnosed disease caused by work activities
- certain 'dangerous occurrences' (near miss incidents)

Further information is available at www.hse.gov.uk/riddor

Serious Incident – Serious incidents in the NHS include acts and/or omissions occurring as part of NHS-funded healthcare that result in:

- Unexpected or avoidable death of one or more people
- Unexpected or avoidable injury to one or more people resulting in serious harm
- Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional to prevent death or serious harm
- Actual or alleged abuse during the provision of NHS-funded care
- Never events (see NHS England Never Events Framework)
- Significant data breach
- Loss of public confidence in the service

5. Incident reporting and management process

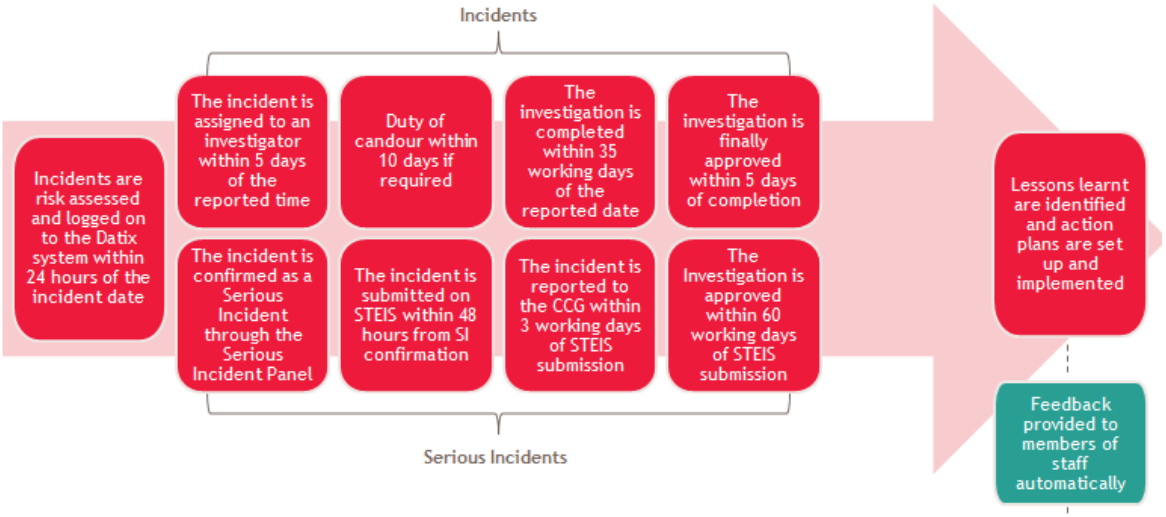
5.1 Key timeframes

Key timeframes within the incident management process and who is responsible:

1. Incident or near miss should be reported on Datix **as soon as is safe and practical to do so**
2. An investigating officer should be assigned **as soon as is practical** after the incident is reported on Datix to review the incident and take immediate action to ensure the safety of staff and patients. In any case, an investigator must be assigned within five calendar days of the incident being reported.
3. Duty of Candour to be discharged as outlined in the Duty of Candour Policy for further information.
4. Investigation completed within **35 calendar days** of the incident being reported.
5. The investigation reviewed and finally approved within **five calendar days** of investigation completion.

Incidents will appear as 'overdue' on Datix after 45 calendar days.

The following flow chart demonstrates the steps above:



Some specialities such as information governance also have legal obligations to report certain incidents with strict timelines. The

Data Protection Act 2018 requires certain incidents to be reported to the ICO within 72 hours of the incident.

5.2 Incident reporting

Incidents must be reported by the staff member who witnessed it. When more than one member of staff witnessed the incident, it need only be reported once. As such, members of staff should decide who reports it.

An incident must be reported on Datix and no further consultation with a manager is required to do so. If the member of staff deems an occurrence to be an incident, it should be reported so a further examination can take place.

An incident report can be made in the following ways:

- Via the intranet, at the link: https://web.datix.thirdparty.nhs.uk/EastOfEnglandAmbulanceServiceNHSTrust/live/index.php?module=INC
- Via the Single Point of Contact phoneline, on: 0345 602 6856
- Via the link on the electronic patient care record

If there is a need to take significant action following an incident to prevent reoccurrence, the reporter may decide to highlight this to the duty manager at the time in addition to reporting the incident on Datix.

The incident report must include the following details (where known):

- Accurate incident date and time.
- Accurate location of where the incident took place.
- CAD or Adastra number (if relevant).
- Accurate details of the people involved.
- A detail and factual account of what happened, including whether the reporter feels that harm was caused as a result of the incident.

There may be local agreements in place to manage certain occurrences outside of Datix. These agreements may include damaged items of uniform or lack of, or broken, equipment at

the start of a shift – if this is the case, no incident is required to be raised on Datix. However, all incidents relating to patient or staff safety must be reported on Datix without delay or consultation.

Incidents maybe identified through the receipt of a concern or complaint or from responses to surveys. The Patient Experience Team will pass these to the safety team for review.

5.3 External reporting of patient safety incidents

The Trust has a duty to report all patient safety incidents to NHS Improvement via the National Reporting and Learning Service (NRLS). This is to assist with national learning and action via the Central Alerting System (CAS). The following incidents should be reported to the NRLS:

- Patient injury
- Medication errors
- Inability to deliver treatment (equipment error or lack of equipment)
- Clinical errors
- Deterioration of patient condition due to response delay

This list is not exhaustive. The patient safety team is responsible for grading and reporting patient safety incidents to the NRLS. This should be undertaken on a monthly basis and should be reviewed by the safety and risk lead prior to upload. There are additional bodies that incidents will be reported to these include: referrals to HSIB, IOPC, HSE etc

5.4 Incidents relating to external organisations

Due to the nature of the work the Trust undertakes, staff have occasion to report incidents and near misses relating to other provider organisations, including hospitals, care homes and care agencies. These incidents are reported on the Trust's incident reporting system (Datix) in the same way as an internal incident.

As these incidents relate to another organisation, it is not possible or appropriate for the East of England Ambulance Service NHS

Trust to conduct the investigation. Our responsibility is to notify the provider organisation of the details of the incident and to share the necessary details to enable them to conduct their own investigation. This can be done in several ways:

- Email (via nhs.net account) to the relevant department at the provider organisation.
- Telephone to the provider organisation's PALS department (document in the incident report on Datix).
- Via external organisation notification letter (template on Datix).

Once this has been passed to the relevant organisation, it is appropriate to close this incident report, providing feedback to the reporter that it has been passed to the correct organisation for their investigation. If feedback is received from the other organisation, this should be attached to the Datix and shared with the staff member at the later date.

5.5 Incident risk scoring and proportionality of investigation

In order to be able to identify what level of investigation is required for an incident, a risk score (using a risk matrix) must first be established.

For further information on risk scoring and proportionally investigating an incident, please see Investigations Guidance.

5.6 Duty of Candour

The Trust is statutorily required to implement the Duty of Candour for appropriate cases as per the Health and Social Care Act, 2008, Regulation 20.

For further information about the Duty of Candour, please see the Duty of Candour Policy.

5.7 Outcomes and learning

Following completion of an investigation, a conclusion must be reached. The Trust advocates the principles of fair blame as part of its just culture and recognises that in many incidents, the root causes of errors are based in process and system errors. The incident management system therefore works on the premise

that investigations are conducted in a non-punitive and supportive manner, unless it is determined that a member of staff has knowingly acted in a reckless, intentionally unsafe, or criminal manner.

Potential outcomes for individual staff involved:

- Discussions about the case and the raising of awareness with regards to how the incident can be avoided. This includes reference to relevant policies, procedures and guidelines.
- Reflective practice or personal development with regards to the cause of the incident.
- Additional training.
- Clinical debrief.
- Referral to Clinical Variations Panel, stage one or stage two.
- If the investigation evidences deliberate, unsafe, or criminal acts, referral to the relevant HR process and referral to relevant professional regulatory body (HCPC/GMC/NMC), or the police, if appropriate.

An incident decision tree is available to use in the Investigations Guidance for instances when support is required to manage a member of staff involved in an incident.

The investigating officer must determine whether the incident is likely to be an isolated occurrence related to the patient or individual staff involved, or whether there is a likelihood of recurrence. In this instance, learning should be shared more widely to minimise recurrence. This can include:

- Memos to staff within the team.
- Team training.
- Amendments to local processes (within the framework of Trust policies and procedures.

If it is felt that Trust wide learning is required, this should be escalated to the patient safety team for review and consideration. Trust-wide actions can include:

- Articles published through the communications team.

- Addition to professional update and induction training.
- New policies/procedures and guidelines

5.8 Feedback to staff

Ongoing contact with the member of staff reporting the incident throughout the course of the investigation is important, in order to ensure involvement of the relevant persons in the investigation.

Upon completion of an investigation, when the incident has been finally approved, Datix generates automatic feedback to the reporter of the incident through the use of the e-mail supplied when the reporter reported the incident, as long as asecure email addres has been provided. This ensures that feedback is always given. If a secure email address has not been provided, the investigating officer should seek contact with the reporter, and give feedback manually if desired.

6. Equality Impact Assessment

The East of England Ambulance Service NHS Trust has made every effort to ensure this policy does not have the effect of discriminating, directly or indirectly, against employees, patients, contractors, or visitors on the grounds of race, age, nationality, ethnic (or national) origin, gender, sexual orientation, marital status, religious belief or disability. This policy will apply equally to full and part time employees. All East of England Ambulance Service NHS Trust policies can be provided in large print or Braille formats if requested, and language line interpreter services are available to individuals who require them.

7. Process for monitoring compliance and effectiveness

The Executive Leadership Team has devolved responsibility for monitoring the incident management process to the Patient Safety Group (PSG). Regular reports identifying trends, remedial action and any organisational learning will be prepared by the patient safety team for submission to the PSG. Assurance papers

will also be provided by the patient safety team to the Quality Governance Committee for Board assurance purposes.
Compliance with the policy will be measured through set standards and Key Performance Indicators (section 8 below).

8. Standards/key performance indicators

- Number of incidents reported per month (monitoring)
- Number of incidents investigations overdue for completion (<100)
- Incident trends and themes (monitoring)

Appendix 1 – Example incidents and near misses (not exhaustive)

Examples of adverse incidents, near misses and other hazards **affecting clients, staff or members of the public**:

- slips, trips falls and collisions
- healthcare associated infection
- incorrect treatment (e.g. failure to defibrillate when indicated)
- any event which results in restraint of a patient by ambulance staff, regardless of section status or presence of other services
- medication errors (e.g. wrong drug, incorrect dosage, incorrect time administered, contra indications to drug not assessed etc)
- adverse reaction to medicines
- accidental injury to a patient or client (e.g. damage to patient's foot during transfer)
- accidental injury to employee or member of the public arising out of work activities
- all road traffic accidents involving Trust vehicles or vehicles used for Trust activities on and off Trust premises
- inoculation, needle stick or sharps incidents
- self-harm incidents
- contact with moving machinery or electricity
- manual handling incidents (including musculo-skeletal injuries)
- physical or verbal abuse or threatening behaviour
- medical device or equipment failure
- contact with harmful or hazardous substances
- client, contractor or staff use of alcohol or illicit drugs on Trust premises
- theft, loss or damage to client, staff or Trust property
- clinical waste and general waste incidents (including spillage of hazardous substances, inappropriate segregation, labelling of waste
- delay in diagnosis, wrong or incomplete diagnosis or incorrect patient assessment
- suspected or actual abuse of vulnerable adults
- unplanned release of hazardous substances into the environment

- dangerous occurrences that require reporting under the RIDDOR regulations
- security incidents - involving people, property, equipment and information
- adverse incident involving contractors and sub contractors, e.g. failure to observe safety rules, poor attitude etc
- Data protection breaches or breaches of confidentiality

Appendix 2 – Equality Analysis

<table>
<tr><th colspan="2">EIA Cover Sheet</th></tr>
<tr><td>Name of process/policy</td><td>Management of Incidents Policy</td></tr>
<tr><td>Is the process new or existing? If existing, state policy reference number</td><td>Existing</td></tr>
<tr><td>Person responsible for process/policy</td><td>Patient Safety Lead</td></tr>
<tr><td>Directorate and department/section</td><td>Clinical Quality and Improvement</td></tr>
<tr><td>Name of assessment lead or EIA assessment team members</td><td>Patient Safety Lead</td></tr>
<tr><td>Has consultation taken place?

Was consultation internal or external? (please state below):</td><td>No</td></tr>
<tr><td></td><td></td></tr>
<tr><td>The assessment is being made on:

Please tick whether the area being assessed is new or existing.</td><td>
<table>
<tr><td>Guidelines</td><td></td></tr>
<tr><td>Written policy involving staff and patients</td><td>X</td></tr>
<tr><td>Strategy</td><td></td></tr>
<tr><td>Changes in practice</td><td></td></tr>
<tr><td>Department changes</td><td></td></tr>
<tr><td>Project plan</td><td></td></tr>
<tr><td>Action plan</td><td></td></tr>
<tr><td colspan="2">Other (please state)</td></tr>
</table>
</td></tr>
</table>

Equality Analysis					
What is the aim of the policy/procedure/practice/event? To document the Trust's process for managing incidents reported via the Datix system, except for serious incidents, which are managed under the Serious Incident Policy.					
Who does the policy/procedure/practice/event impact on?					
Race	☐	**Religion/belief**	☐	**Marriage/Civil Partnership**	☐
Gender	☐	**Disability**	☐	**Sexual orientation**	☐
Age	☐	**Gender re-assignment**	☐	**Pregnancy/maternity**	☐
Who is responsible for monitoring the policy/procedure/practice/event? Patient Safety Lead					
What information is currently available on the impact of this policy/procedure/practice/event? No impact – every person affected by an incident or its investigation is treated equally.					
Do you need more guidance before you can make an assessment about this policy/procedure/ practice/event? No					
Do you have any examples that show that this policy/procedure/practice/event is having a positive impact on any of the following protected characteristics? No					
Race	☐	**Religion/belief**	☐	**Marriage/Civil Partnership**	☐
Gender	☐	**Disability**	☐	**Sexual orientation**	☐
Age	☐	**Gender re-assignment**	☐	**Pregnancy/maternity**	☐

Please provide evidence:
Are there any concerns that this policy/procedure/practice/event could have a negative impact on any of the following characteristics? No **Race** ☐ **Religion/belief** ☐ **Marriage/Civil Partnership** ☐ **Gender** ☐ **Disability** ☐ **Sexual orientation** ☐ **Age** ☐ **Gender re-assignment** ☐ **Pregnancy/maternity** ☐ Please provide evidence:
Action Plan/Plans - SMART N/A
Evaluation Monitoring Plan/how will this be monitored? N/A

Appendix 3 – Monitoring Table

What	*Who*	*How*	*Frequency*	*Evidence*	*Reporting arrangements*
Compliance with complaints SI SOP audit	PEEG/QGC	Audit	At each meeting	Audit sheet/ report	Report to PEEG/ QGC
Reporting of incidents.	PSG/ CRG/ QGC	Metrics report/ Dashboard	At each meeting	Datix reports on how many incidents re reported by month and by area. In detail to PSG by exception to CRG and QGC.	PSG/ CRG/ QGC reports
Trends and Themes	PSG/ CRG/ QGC	Metrics report/ Dashboard	At each meeting	Analysis of the types of incidents and geographical variations. In detail to PSG by exception t CRG and QGC.	PSG/ CRG/ QGC reports

SI actions completed	PSG/ CRG	Metrics report/Dashboard	At each meeting	Report to PSG. Escalation to CRG when concern raised by PSG.	PSG/ CRG
Lessons Learned	PSG/ CRG/ QGC	Metrics report/ Dashboard	At each meeting	In detail to PSG by exception t CRG and QGC.	PSG/ CRG/ QGC reports
. Delays in investigation and action completion.	PSG/ CRG/ QGC	Metrics report/ Dashboard	At each meeting	In detail to PSG by exception t CRG and QGC.	PSG/ CRG/ QGC reports