THE MAZE GROUP CIC

Incident Reporting Policy
in accordance with PSIRF (Patient Safety Incident Reporting Framework)

Issued: April 2026

Version: 1.0

Policy Approval

Author	Business Manager
Approved by	Board of Directors
Date	09 July 2025

Issue and Revision Log

Issue	Date Issued	Date for Review	Notes
1.0	May 2025	May 2026	
1.0	April 2026	April 2028	Review carried out by ICB

Contents

1. Purpose and Scope

This policy outlines The MAZE Group CIC's ("MAZE") approach to identifying, reporting, and responding to patient safety incidents in accordance with the Patient Safety Incident Response Framework (PSIRF). It ensures a consistent and transparent process for managing incidents, in a way that promotes learning and improvement across the organisation.

This policy applies to all staff members, volunteers, contractors, and service providers involved in the care of patients or clients.

2. Patient Safety Incident Response Framework (PSIRF)

In alignment with the transition from the Serious Incident Framework (2015), this organisation fully adopts the principles of PSIRF, which provides a flexible and learning-oriented approach to incident response.

PSIRF Four Key Aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents.
2. Application of a systems-based approach to learning from incidents.
3. Considered and proportionate responses to patient safety incidents.
4. Supportive oversight focused on improvement and assurance.

3. Definition of a Patient Safety Incident

A *patient safety incident* is defined as:

"Any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving healthcare."

NHS Levels of Harm:

Level	**Definition**
No Harm	Incident occurred but resulted in no harm to the patient.
Low Harm	Any unexpected or unintended incident requiring extra observation or minor treatment.
Moderate Harm	An incident resulting in a moderate increase in treatment, significant but not permanent harm, or prolonged psychological harm.
Severe Harm	Permanent harm caused to one or more patients.
Death	Incident that directly led to the death of a patient.

4. Duty of Candour

In accordance with the statutory Duty of Candour, we are committed to being open and transparent with patients and their families when moderate or greater harm has occurred. This involves:

- Notifying the patient or their representative.
- Providing a truthful explanation of what happened.
- Offering a sincere apology.
- Keeping the patient informed about actions taken in response to the incident.

5. Incident Notification and Investigation Process

- All incidents must be reported promptly through the internal incident reporting system (see Appendix 1).
- Incidents will be assessed and categorised according to the level of harm.
- For moderate harm or above, the Integrated Care Board (ICB) will be notified promptly.
- The ICB may offer support in the investigation process and guide the appropriate system-based review under PSIRF.
- Investigations will focus on learning and system improvement, rather than individual blame.

6. Support and Learning

All staff members, volunteers, contractors, and service providers involved in incidents will be treated with empathy and provided with the necessary support. Learning from incidents will be widely shared across the organisation through safety briefings, training, and policy reviews.

7. Monitoring and Review

This policy will be reviewed bi-annually or sooner if national guidance changes. Compliance with the PSIRF and Duty of Candour will be monitored through routine audits and feedback mechanisms.

APPENDIX 1
INCIDENT REPORTING FORM

For internal use within The MAZE Group Community Interest Company
CONFIDENTIAL – FOR QUALITY IMPROVEMENT PURPOSES

Section 1: Incident Details

- **Date of Incident:**
- **Time of Incident:**
- **Location of Incident (e.g., home visit, clinic, outreach):**

Section 2: Person(s) Involved

A. Patient/Service User Details (if applicable):

- Full Name:
- NHS Number (if known):
- Date of Birth:
- Was the person harmed? ☐ Yes ☐ No
- If yes, describe the nature of the harm:

B. Staff/Other Involved Individuals:

- Name(s):
- Role(s):

Section 3: Incident Description

Please describe what happened (factual, objective account):

What was the immediate response/action taken?

Section 4: Impact and Severity Assessment

- **Level of Harm (tick one):**
  ☐ No Harm
  ☐ Low Harm
  ☐ Moderate Harm
  ☐ Severe Harm
  ☐ Death
- **Does the incident meet the threshold for statutory Duty of Candour?**
  ☐ Yes ☐ No ☐ Unsure
- **Was the affected person/family informed?**
  ☐ Yes – Verbally
  ☐ Yes – In writing
  ☐ No
  ☐ Pending

- **Was the Integrated Care Board (ICB) contacted for moderate or above harm?**
  ☐ Yes ☐ No ☐ Not yet – Plan to contact

Section 5: Reporter Information

- **Name of Person Completing Form:**
- **Role/Job Title:**
- **Date of Report Submission:**
- **Contact Information (email or phone):**

Section 6: Management Use Only

(To be completed by Line Manager/Clinical Lead or Governance Officer)

- **Incident Classification:**
- **Action Taken/Planned:**

- **PSIRF Response Type (if applicable):**
  ☐ Local learning response
  ☐ Patient safety incident investigation (PSII)
  ☐ Other:
- **Duty of Candour Follow-up Completed:** ☐ Yes ☐ No
- **Review Outcome/Next Steps:**

- **Reviewed by (Name/Role):**
- **Date of Review:**

Please submit this form to the business team within 24 hours of the incident.

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